

CLINICIAN PERCEPTIONS OF THE IMPACT OF EMOTIONS ON CLINICAL DECISION
MAKING IN CHILD AND ADOLESCENT EATING DISORDERS

by

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Abstract

This thesis will examine the impact of emotions on clinical decision-making in the field of child and adolescent ED. Therapists and medical professionals working with chronic and life-threatening illnesses, such as ED may be particularly vulnerable to emotional influences on their decision-making. This is evident, as past research studies have identified that high levels of clinician anxiety result in lower adherence to treatment protocol. In a survey, clinicians reported that the top three decision categories they perceive to be the most emotionally charged include: 1. Involvement of the family; 2. Autonomy and Control; and 3. Food and Weight. The decision rated as most negatively influenced by clinician emotion was the decision to include a critical/dismissive parent in treatment. Family-based therapy has the most empirical support in the treatment of child/adolescent ED. A treatment team consists of a physician and therapist at minimum; however, studies examining medical professionals indicated that they were not confident in their training in ED or in the treatment of ED and only 1/3 of medical professionals report always including the family in therapy. As such, interviews were conducted in order to gain a better understanding of the impact of emotions on clinical decision-making in clinicians and medical professionals. 22 participants (16 therapists and 5 medical professionals) working in the field of child and adolescent ED completed a 1 hour semi-structured interview that included questions regarding clinician and medical professionals perceptions of the impact of emotions on clinical decision making in themselves and in their colleagues. Transcripts were analyzed using thematic analysis. The themes identified suggest that clinicians and medical professionals perceive emotional influences on their decision-making in clinical practice. The results are discussed in terms of the implications for self-reflective practice.

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CHAPTER 1: INTRODUCTION

Clinical decision-making is imperative for competent functioning as a clinical psychologist (Westin & Weinberger, 2005) and is a central element of the medical profession (Kienle & Kiene, 2010). There are many factors that influence one's ability to make sound decisions in a clinical setting, including time constraints, ambiguity, stress, and high-cost outcomes (Smith, Higgs, & Ellis, 1991). Research has also emerged suggesting that clinical decision-making can be influenced by clinician emotion (i.e. Bellon & Fernandez-Asensio, 2002; Lafrance Robinson & Kosmerly, 2014). Therapists and medical professionals working with chronic and life-threatening illnesses may be especially vulnerable to the influence of their emotions when making clinical decisions due to the frequency of visits made by clients and the medical uncertainty associated with these types of illnesses (Bellon & Fernandez-Asensio, 2002). However, clinicians show reluctance in discussing the importance of emotion in decision-making in a clinical setting (Brown 2004; Brown, 2005). For example, a survey conducted by Brown (2004) found that less than twenty percent of clinicians (e.g, physicians and nurses) who worked with chronic illnesses acknowledged that emotions played an important role in their treatment decisions. Brown (2005) conducted a follow-up survey to examine clinicians' reluctance to discuss emotions, given that they are important in clinical decision-making in clients with chronic pain. Clinicians reported that their reluctance to acknowledge the role of emotions in their practice was influenced by: 1) their belief that emotions are unprofessional in a clinical setting, 2) their need to protect themselves (self-preservation) by not getting emotionally involved in their work and remaining objective, 3) their years of experience, such that less experience was attributed to 'hiding' behind the evidence base and shying away from emotion,

4) their desire to avoid their own emotions because they lacked skills necessary to cope with them, and 5) difficulties empathizing with clients because they have not experienced chronic pain in their own lives.

Research has recently begun to examine this phenomenon in clinicians working with eating disorders (ED). In addition to being chronic, ED are also life threatening and resistant to treatment. Lafrance Robinson and Kosmerly (2015) examined clinicians' perceptions of the influence of their own emotions and the emotions of their colleagues on clinical decision-making in the context of child and adolescent ED. Overall, clinicians surveyed stated that emotions impact the ability to make clinical decisions at least some of the time and they were about twice as likely to report that this phenomenon occurred in their colleagues. Of these clinicians, a subsample was contacted for an interview. The current thesis consisted of two studies: Study 1 and Study 2. Study 1 incorporated the qualitative method of Theoretical Thematic Analysis (TTA) to explore ED therapists' experiences with emotions and the perceptions of their impact on decision-making in clinical practice. Given that in the field of eating disorders, it is considered best practice for therapists to work collaboratively with a medical professional (Lock & le Grange, 2013), Study 2 also employed TTA to analyze interviews conducted with medical professionals in this field to provide an understanding of their experiences with emotions in clinical practice. Finally, themes identified from the data from therapists (Study 1) and medical professionals (Study 2) were compared to determine the ways in which these two fields are similar and different with regard to the evocation of emotions in clinical practice and their perceived influence in clinical settings.

1.1 Eating Disorders

ED are life-threatening illnesses that have the highest mortality rate of all the psychiatric disorders (Reijonen, Pratt, Patel, & Greydanus, 2003). ED can lead to a reduction in lifespan of up to 25 years (Norris, Bondy, & Pinhas, 2011) and are considered to be the third most common chronic illness among adolescent girls (Goni & Rodriguez, 2007). The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) includes the chapter “Feeding and Eating Disorders”, which classifies ED into three categories based on symptomatology: Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Binge Eating Disorder (BED). AN is characterized by a restriction in food intake that leads to significantly low body weight compared to other individuals of the same age and sex, an intense fear of gaining weight, and a distorted image of one’s own body. The DSM-5 describes BN as an unhealthy pattern of eating behaviour that involves bingeing, by which the individual consumes a large amount of food in a short period of time and then feels a loss of control over food consumption and recurrently engages in unhealthy compensatory behaviours, such as purging, laxative use, or excessive exercise. Such unhealthy compensatory behaviours are an attempt to purge the body of the calories consumed. BED is characterized as bingeing behaviour and a loss of control over eating in the absence of compensatory behaviour. Optimal treatment of ED involves a team approach. The treatment team is made up of (at minimum) a physician to monitor physical health and a therapist (Lock & le Grange, 2013).

1.2 The Role of Emotions in Adolescent Eating Disorders

The role of emotions in ED has been researched in the context of the affected individual, the caregiver and, more recently, the clinician. Greenberg and Paivio (1997) defined emotions as “fundamentally adaptive” in nature, such that organisms are able to process complex situational

information in a quick and automatic way in order to act in a way that meets important personal needs. In other words, each emotion acts as a signal to the body to orient people to their environment and promote their well-being (e.g., self-protection and support; Greenberg & Paivio, 1997). Emotions are important because they signal an important need, value, or goal may be protected or harmed in a certain situation and they determine how individuals appraise themselves and their world (Greenberg, 20014). Emotions also enable individuals to understand what is important and this knowledge directs individuals to know what they need to do and who they are (Greenberg and Paivio, 1997).

ED are characterized by emotional processing deficits including difficulties identifying and labeling affective experiences such as anger or sadness (Becker-Stool & Gerlinghoff, 2004; Bydlowski et al., 2005). An ED can be conceptualized as a means for the affected individual to control and manage negative emotions (Treasure, Schmidt, & Troop, 2000). Starving numbs or helps the individual avoid the painful emotions, bingeing soothes the painful emotion, and purging provides relief from the emotion (Dolhanty & Greenberg, 2007). The role of emotion and its avoidance is central to the onset and maintenance of ED (Dolhanty & Greenberg, 2007). Thus, the field has recently been turning its attention to the role of emotion in the treatment of ED (Becker-Stool & Gerlinghoff, 2004; Bydlowski et al., 2005; Lafrance Robinson, Dolhanty, & Greenberg, 2013).

Theoretical models have emerged that highlight the influence of caregiver emotion on the onset, treatment, and recovery of those affected with an ED (Lafrance Robinson et al., 2013b; Schmidt & Treasure, 2006; Treasure et al., 2008). For instance, the Cognitive-Interpersonal Maintenance Model of ED posits that when their loved one is ill, caregivers can experience emotional arousal (e.g., anxiety), which can lead them to engage in behaviours that may

contribute to ED maintenance (e.g., accommodating and enabling behaviours; Treasure et al., 2008). One aspect of the model suggests that interpersonal mechanisms are important to the maintenance of the ED (Treasure et al., 2008). For example, often people close to the individual with AN compliment them about their initial weight loss. These compliments reinforce the individual's efforts to restrain food intake as well as their commitment to AN in order to feel attractive, special, or more confident. As the illness progresses, close others become worried about their loved one and many families become organized around the needs of the person with AN who required extra care and attention. Alternatively, AN may elicit strong negative emotions in family members because of the person's unwillingness to accept the need for change and the stress that the illness is putting on the family. In this case, the caregiver's own feelings of helplessness or self-blame for not being able to help their loved one translates into overt criticism of the person with AN. The person with AN may then distance herself from her loved ones because of her inability to deal with negative emotions and her sensitivity to criticism. Treasure et al. (2008) suggest that the responses of close others such as parents can influence the formation and elaboration of pro-anorectic beliefs, which in turn can lead to justification of the need for further starvation in order to reduce the threat in those with avoidant, perfectionist, and obsessional personalities.

1.3 The Role of Clinicians' Emotions in Child and Adolescent Eating Disorders

Like the affected individual and their caregiver, the delivery of treatment is an emotional experience for the ED clinician. For instance, Thompson-Brenner, Satir, and Franko (2012) conducted an extensive literature review and found that clinician reactions to individuals with ED included frustration, hopelessness, insecurity, and worry. A survey of job burnout in highly experienced ED treatment providers revealed that 45% of the participant sample reported that

treatment resistance, egosyntonicity, high relapse rates, worry about patient survival, emotional drain, lack of appropriate financial reimbursement, and extra hours spent working, contributed significantly to feelings of burn-out (Warren, Schafer, Crowley, & Olivardia, 2013). Overall, emotional exhaustion was found to be the most common contributing factor to burn-out in ED clinicians.

Recent research has begun to examine the ways in which clinicians' emotional reactions influence the delivery of treatment of individuals and families in the context of ED. Two models, The Therapist Drift Model (Waller, 2009) and The Iatrogenic Maintenance Model of Eating Disorders (Treasure, Crane, McKnight, Buchanan, & Wolfe, 2011) have been proposed to better understand the role of emotions in clinical practice.

1.4 The Iatrogenic Maintenance Model of Eating Disorders

The Iatrogenic Maintenance Model of ED identifies clinical factors that may inadvertently play a role in perpetuating ED behaviour. The theoretical model proposes that four factors related to the clinician may negatively affect the treatment of ED: interpersonal factors, pro-eating disorder beliefs, thinking style, and emotional style. Interpersonal factors refer to clinician characteristics such as overprotectiveness, hostility, criticism, confrontation, coercive treatments, or accommodation, all of which may reinforce ED symptoms. For example, clinicians may act in an overprotective manner by resorting to the use of intensive treatments, such as inpatient treatment too readily and for too long of a time period. Critical and confrontation-coercive treatments may involve loss of privilege to motivate change.

Clinicians can also engage in accommodating and enabling behaviours, such as bargaining of treatment goals or providing the opportunity for striving and competing against each other. Pro-eating disorder beliefs refer to the believing that positive consequence can occur

as a result of the ED (i.e., starvation results in mastery and control). In addition to negative conditioning to food due to AN, cognitive, emotional, and interpersonal factors can produce conditioned food aversions. For example, food aversions can develop with the use of coercive feeding practices, which use punishment or guilt to pressure an individual to eat. This form of evaluative conditioning is resistive to extinction. According to the model, if strict refeeding programs use high levels of coercion, the clinician may inadvertently reinforce the ED. Often foods used to refeed become associated with weight gain. These types of food produce fear in the individual, which can make the person feel as though they cannot maintain their weight while eating normal foods or may lead the person to act out in anger or frustration by bingeing on these foods. If the emotions experienced throughout treatment are overwhelming, the client may view the recovery from ED as a negative experience.

Thinking style can also interfere with treatment when the clinician is rigid in their definition of recovery (Treasure et al., 2011). For instance, the inpatient environment is often highly structured with routines and rules. This type of environment can be valued in individuals with an obsessive-compulsive temperament because it produces a feeling of security; however, this environment also accommodates obsessive-compulsive traits. This routine environment can lead to distress when leaving the treatment center and being in an environment that is not structured or routine. Clients can often display all-or-nothing thinking, which can be mirrored by clinicians. When clinicians see recovery in an all-or-nothing manner, this can foster a sense of hopelessness and shame in the client. Finally, emotional style, or the emotional states experienced by the clinician can result in avoidant practices as a method of reducing their own negative emotions. Unhelpful therapeutic relationships can develop between the therapist and the client. For example, when a client is losing weight at a rapid pace or is medically unwell, the

therapist may become anxious and choose to avoid the situation. Therapists may experience unhelpful cognitions (e.g., shame about their own helplessness) or unhelpful behaviour, such as nagging the client about food intake. In order to avoid a hostile reaction in a client, the clinician may negotiate with the client with regard to treatment recommendations. Clinicians may engage in this process to reduce the hostile response from the client and in an attempt to reduce their own discomfort (Treasure et al., 2011)

1.5 The Therapist Drift Model

The “Therapist Drift Model” (Waller, 2009) was developed to examine the ways in which clinicians can contribute to the ineffectiveness of Cognitive-Behavioural Therapy (CBT) for ED by allowing therapy to “drift” off target by applying CBT inappropriately or ineffectively. Therapist Drift often occurs when the clinician is confronted with an immediate crisis in therapy. In these instances, clinicians often fail to plan the overall progress of therapy. As such, CBT clinicians drift away from the purpose of therapy without a plan for dealing with the problem and returning to treatment. The model describes three clinician-factors that may interfere with clinical decisions: clinician cognition, clinician behaviour, and clinician emotion.

Clinician cognition refers to clinician biases, which can result in blaming the client for lack of progress, failing to recognize when treatment is not working, and failing to consider alternative and more appropriate models of treatment when necessary. Because clinicians are human, they are prone to the same cognitive biases as their clients. Fundamental attribution bias makes it more likely that clinicians make external attributions for treatment failures (Waller, 2009). Fundamental attribution bias could make it less likely that clinicians see CBT failing due to reasons that are patient-or-therapy-centered, and they may ignore the fact that clinicians are often active agents in therapy failing. Positive attribution bias can be reinforced by the patients’

tendencies to self-blame, making it less likely that clinicians will consider their own role in treatment failures (Waller, 2009).

Clinician behaviour was also suggested to interfere with therapy (Waller, 2009). For instance, at times when clinicians are unable to work at an optimal level (e.g., ill or fatigued), the fatigue and stress of the clinician can have an impact on their ability to dedicate time and energy to planning the treatment and can reduce the clinician's flexibility. Additionally, clinicians may not push for behavioural changes in their clients despite knowing the efficacy of such elements of treatment are among the most powerful (Waller, 2009). This phenomenon is often the result of safety behaviour on the part of the therapist, such that clinicians want to improve their client's health and it seems difficult to reconcile the use of behavioural methods due to increasing the patient's anxiety during such tasks (Waller, 2009).

Finally, clinicians' own emotions can cause them to drift from treatment protocol. Positive emotions in the clinician can have a negative effect on clinicians' judgment because they can be a distraction from important clinical information (Waller, 2009). For instance, a clinician may become overly excited about a small accomplishment in the client's treatment, which can then take attention away from the main focus of treatment. If clinicians experience negative emotions, such as anxiety, fear, guilt, or shame, they may engage in avoidant practices in an attempt to reduce such negative emotions. For example, the avoidant behaviour on the part of the clinician may be the omission of a certain therapeutic task, such as weighing the client at the beginning of a session.

Waller, Stringer, and Meyer (2012) conducted an experiment to evaluate the Therapist Drift Model (Waller, 2009) and results indicated that clinician anxiety was related to a lower adherence to treatment protocol. For example, only half of the clinician participants reported

using a CBT manual in their work with clients with ED. Although there is a lack of supporting evidence for pre-therapy motivational work (Waller, 2011), the majority of therapists reported using this technique (Waller et al., 2012). No widely supported CBT technique was used routinely by clinicians. In fact many clinicians reported using no CBT techniques at all (Waller et al., 2012). Clinicians who experienced more anxiety were less likely to ask patients to complete food diaries, engage in structured eating, or undertake behavioural experiments. In other words, when anxiety is high, clinicians seem to “drift” away from empirically supported treatment protocol (Waller et al., 2012).

Waller and Turner (2016) discussed the explanations as to why evidence based therapies may be delivered inappropriately or inadequately by well meaning clinicians. Waller and Turner (2016) describe the three elements of effective therapy as follows: the therapy has to work or be evidence-based and manualized, the patient needs to engage in therapy, and the therapist has to deliver therapy effectively. These researchers theorized that the therapist drift occurs for a number of reasons, such as knowledge base, beliefs, philosophical stance, self-belief, and clinical judgment. Waller and Turner (2016) suggest that monitoring clinicians via client outcomes and responding when clinicians are less effective than others or show signs of worsening results may reduce therapist drift. In these cases, clinician adherence to treatment protocol should be verified, and additional training may be required.

1.6 The Therapist Drift Model in Family-based Therapy

Research on the Therapist Drift Model has also examined the role of clinician emotion in the context of Family-based Therapy (FBT) specifically. FBT has the most empirical support for the treatment of child and adolescent ED (Lock & le Grange, 2013). FBT has three specific phases to which a clinician or practitioner must adhere. During phase one, the main focus of the

clinician is to support the family to normalize eating behaviour (in the case of AN) and interrupt symptoms (in both AN and BN). In phase two, the clinician supports the family in returning control of eating to the child. In phase three, the focus shifts to the development of the child's identity. The clinician helps the family to identify and work through unresolved issues that are not related to the child's ED (Lock & le Grange, 2013). Kosmerly et al. (2014) tested the Therapist Drift Model in the context of FBT for child and adolescent ED. Results indicated that clinicians with higher levels of anxiety were less likely to adhere to treatment protocol. Specifically, they were less likely to weigh the client at the beginning of each session and this reluctance to weight the client was noted more often when working with younger children in comparison to adolescents (Kosmerly et al., 2014).

1.7 The Role of Clinician Emotion in the Treatment of Child and Adolescent ED

Qualitative research has also explored the role of clinician emotion in the treatment of child and adolescent ED and specifically in the adherence to FBT protocols. Interviews with FBT clinicians revealed that clinicians report facing several barriers when implementing FBT and these were divided into broad categories in order to capture the various phenomena reported by participants (Couturier et al., 2013). One category that emerged as a barrier to clinician adherence to FBT treatment protocol was termed "Therapist Factors" and included factors such as experience in the field of eating disorder treatment, comfort in working with adolescent and families, motivation to implement FBT, and belief in the value of FBT.

In 2015, a survey by Kosmerly and Lafrance Robinson examined the role of emotions when making clinical decisions in the treatment of adolescent ED in Canada. Seventy-five percent of the sample reported the use of FBT as their primary modality of therapy when working with child and adolescent ED. Results revealed that clinician emotion was perceived to

impact clinical decisions at least some of the time and clinicians were twice as likely to suggest that this phenomenon occurred in their colleagues. Clinicians reported that the decisions they perceived to be the most negatively influenced by emotion overall related to the involvement of the family in treatment, and in particular, the inclusion of a critical or dismissive parent. Other decisions rated as emotionally charged included decisions relating to autonomy and control (in particular determining an acceptable level of physical activity/sports activity), as well as decisions regarding food and weight, such as increasing calorie recommendations. Lafrance Robinson and Kosmerly (2015) suggested that given the variety in treatment decisions identified by clinicians as negatively influenced by emotion, it is important that the field continue to turn its attention to this phenomenon in order to prevent emotions from hindering clinical care.

1.8 The Role of Medical Professionals in Child and Adolescent Eating Disorders

While therapists are important to the recovery process – and in particular in FBT, they work as a part of a treatment team. At minimum, the treatment team must also consist of a medical professional who monitors vitals and physical health and who then communicates this information to the therapist in order to inform the direction of the therapy (Lock & le Grange, 2013).

Katzman, Peebles, Sawyer, Lock, and Le Grange (2013) reviewed the role of the pediatrician in FBT for adolescents with ED. The pediatrician's role in FBT is to act as a consultant to the parents and the primary therapist by offering guidance and feedback. The pediatrician is not involved in directing the client's care unless safety concerns are present. The authors discuss that this role requires the pediatrician to have humility and a willingness to defer many patient care issues to the parents and therapist, some of which may seem medical. For example, pediatricians may have to trust the parent to refeed the child rather than having the

child eat meals under the observation of the hospital staff. Pediatricians also provide a comprehensive medical assessment and ongoing medical monitoring and are responsible for explaining the medical seriousness of ED and relaying other relevant information that the therapist could use in treatment.

With regard to the pediatrician's interactions with the parents, it is important that the pediatrician make clear to the parents that they are not to blame for their child's ED. Pediatricians should also avoid being directive, and instead empower parents in decision-making practices in their child's recovery. The pediatrician must also aim to help the parents differentiate the eating disorder from the child. Katzman et al. (2013) note that misconceptions about the focus, content, and process of FBT by pediatricians can lead to problems in the multidisciplinary team and family. These problems can be communicated to other providers or families and can result in recommendations and clinical decisions that are counterproductive.

1.9 Reflexivity

When conducting qualitative research, the researcher is also considered to be the research instrument, such that the unique qualities of the researcher have the potential to influence the collection and analyses of data (Pezalla, Pettigrew, & Miller-Day, 2012). Reflexivity involves a process of critical self-evaluation of the researcher's position in the research and an active acknowledgement and recognition that the researcher may affect the research process as well as the outcome of the research (Bradbury-Jones, 2007). In order to engage in self-reflexivity, the researcher must acknowledge the effect of their own ethnicity, gender, religion, and values on the research process and outcome (Merriam, 2002). As such, the following is an exploration of my personal and professional background and the ways in which myself, as the researcher, could have influenced the outcomes of the present study.

The current research project was influenced by my involvement with a mental health outreach program in my community. This volunteer opportunity afforded me the ability to work with individuals with varying types of mental illnesses (e.g., depression, anxiety, addiction, etc.). During this volunteer opportunity, facilitating a therapeutic writing program allowed me to witness first hand the emotional experiences of professionals, including medical professionals and therapists who were evoked when working with clients in a therapeutic setting. My experience working with individuals with mental illness led me to apply to a Master of Arts in Applied Clinical Psychology. When applying to this program, I was particularly interested in working with Dr. Adele Lafrance due to her work with emotions and eating disorders.

Dr. Lafrance had a profound influence on the current thesis. Dr. Lafrance encouraged me to build on her previous research, which examined the perceived influence of emotions on clinical decision-making in a large sample, including medical professionals, social workers, dietitians, psychologists, etc. through quantitative methods. Due to previous experience in qualitative research, I was eager to analyse interviews conducted with medical professionals and therapists regarding the influence of their emotions on clinical decision-making in child and adolescent eating disorders, as I hoped to be able to provide a more comprehensive explanation regarding this phenomenon. Being aware that the treatment team was important to the treatment of child and adolescent eating disorders and that medical staff and therapists play very different roles, I wanted to examine the perceived influence of emotions on clinical decisions in medical professionals and therapists separately and then compare for similarities and differences in their self-perceptions.

My Master's degree required that I complete 400 clinical hours during my second year of study, which I completed at Nova Scotia Health Authority's Eating Disorder Program in Halifax, Nova Scotia. During my practicum, I had the opportunity to work closely with therapists (clinical psychologists and a psychiatrist) and adults diagnosed with anorexia nervosa and bulimia nervosa. Although FBT was not the primary modality of practice, I was personally able to experience emotions being evoked during both group and individual therapy. I was also able to observe this phenomenon in my colleagues as they demonstrated an open dialogue regarding the emotions being evoked during practice. Many of the themes that emerged from the interviews were observed in my clinical practicum. For instance, when team members experienced strong emotions, they often brought up the issue in team rounds. During team rounds, colleagues offered support by validating the team member's emotions and openly discussing next steps in order to reduce the influence of emotion on clinical decisions.

Interestingly, I also found myself in a situation in which my own emotions regarding a client's experience were influencing my decision-making regarding practicing a specific type of therapy. Through the recognition of my own fear and shame regarding the delivery of therapy, I was able to express my emotions during supervision, and work through them to ensure that I was able to make decisions regarding therapy that were in the best interest of the client. During data analysis of the current thesis, I kept a reflexive journal and noted any emotions or biases that came up for me. When emotions did arise, I engaged in self-reflective practices by examining why I was feeling certain emotions in relation to the data. I was also able to consult with my supervisor, Dr. Lafrance regarding my own emotions evoked through the data analysis process and she was able review the document and offer guidance to ensure that my own emotions were not influencing my interpretation of the data. This process has taught me that clinicians are

human beings, and like all humans, we experience emotions when working in the mental health field and these have the potential to influence decision-making in clinical practice. Rather than ignoring or suppressing these emotions, it is crucial that we acknowledge them through self-reflective practices and seek out consultation from other team members to ensure that we make decisions that are in the best interest of the client.

My clinical and research experience regarding this topic has inspired me to continue my studies by pursuing a PhD in Clinical Psychology. I hope to further research the role of clinicians' emotions, parents' emotions, and the child/adolescents' own emotions in the treatment of eating disorders in the future.

1.10 The Current Studies

This thesis consists of two studies. Based on the body of literature discussed, *Study 1* extends the research of Lafrance Robinson and Kosmerly (2015) on clinicians' perception of the influence of emotion on clinical practice and involves the analysis of qualitative interviews conducted with a subset of the original survey sample. The qualitative examination provides a comprehensive understanding of the emotion-focused experiences of clinicians when offering clinical services in the context of child and adolescent eating disorders. Specifically, the aim of this study is to provide an in-depth exploration of emotions that are evoked in clinicians during the delivery of treatment and the overall perceptions of the influence of emotion in clinical decisions in the treatment of child and adolescent ED.

While physicians are highly involved in the treatment of child and adolescent eating disorders, there is evidence to suggest that they may not feel competent in their knowledge when it comes to treatment (Boule & McSherry, 2002; Griz et al., 2014). Among other factors, self-

assessed barriers, such as lack of skill, case complexity, and lack of resources were reported by medical professionals to affect their ability to treat children with ED (Lafrance Robinson et al. 2013a), and which may evoke emotion in the medical staff when doing so. Because the role of emotion was found to have an impact on clinicians' decision-making in child and adolescent ED (Lafrance Robinson & Kosmerly, 2015), it is important to examine this phenomenon in medical professionals, as they are a vital part of the treatment team and may also be vulnerable to this phenomenon. As such, Study 2 examines the emotions that arise in medical professionals during treatment as well as the perceived impact of medical professionals' emotions on clinical practices in child and adolescent eating disorder.

CHAPTER 2: METHODOLOGY AND METHOD

2.1 Participants Study 1. A subset of therapists from Lafrance Robinson and Kosmerly's (2015) original study volunteered to be interviewed and sixteen of these volunteers were included for qualitative interviews. Inclusion criteria included using FBT as a primary modality and working as part of a treatment team. The sample included five psychologists, two psychological associates, eight social workers and one unspecified therapist. Participants worked in both urban and rural settings and in outpatient, inpatient, and day treatment programs. Participants also worked in a variety of settings, such as hospital-based and community-based programs.

2.2 Participants Study 2. A subset of medical professionals from Lafrance Robinson and Kosmerly's (2015) original study volunteered to be interviewed and five of these volunteers were included for qualitative interviews based on inclusion criteria. Inclusion criteria included using FBT as a primary treatment modality and working as a part of a treatment team. Participants included medical professionals involved in the medical monitoring and treatment of children with ED. The sample included two nurse practitioners, one nurse, one pediatrician and one family physician. Participants worked in both urban and rural settings in a variety of programs, including hospital-based and community programs.

2.3 Semi-Structured Interview Schedule

An interview schedule was developed based on the methodology of basic interpretive qualitative research (Merriam et al., 2002), Treasure et al.'s (2011) Iatrogenic Maintenance Model, Waller's (2009) Therapist Drift Model, the FBT Manuals for AN (Lock & le Grange, 2013) and BN (le Grange & Lock, 2007), and a review of the literature on emotions and their role in clinical decision-making. The interview schedule was semi-structured and included questions regarding the impact of emotions on clinical decision-making in both the clinician and

their colleagues. Sample questions include: “Thinking about your colleagues: Which clinical decisions are the most influenced by a clinician’s emotions? (i.e. setting goal weights, recommending tertiary care, etc.) What about for yourself?” (Refer to full interview guide in Appendix 1). The participants were asked follow-up questions when appropriate.

Basic Interpretive Qualitative Research (Merriam, 2002) suggests that people construct their reality in interaction with their social worlds. Phenomenology and Symbolic Interactionism inform Basic Interpretive Qualitative Research (Merriam, 2002). Phenomenology contributes the idea that people interpret everyday experiences from their own perspective of the meaning that it has for them. Symbolic Interactionism contributes in that it focuses on interpretation within the context of larger society. For instance, individuals act in specific ways based on the meaning that the situation has for them. Meaning is constructed through social interaction and it is adapted through interpretation. Basic Interpretive Approach is interested in the ways in which individuals interpret their experiences, the ways in which they construct their worlds, and the meanings that they attribute to their experience. In other words, Basic Interpretive Approach aims to understand the ways in which individuals make meaning of a given situation (Merriam, 2002).

2.4 Procedure

Clinicians who agreed to partake in an interview were contacted via telephone. At the beginning of the interview, the participants were informed that they could skip any question they did not want to answer and they could stop the interview at any time. The interviews took place between January and August 2013. Each interview took approximately 60 minutes and the interviews were recorded and transcribed verbatim.

2.5 Analysis

The interviews were analyzed for themes and patterns across the data set using Theoretical Thematic Analysis (TTA). The TTA process was driven by the researcher's theoretical interest in the subject area and data were coded for a specific research question. TTA consists of six stages (Braun & Clarke, 2006). During the first stage of TTA (Braun & Clarke, 2006), the researcher familiarized herself with the data, which involved the researcher immersing herself in the data, such that the researcher read and re-read the transcripts in an active way to search for themes and meaning.

Phase two involved generating initial codes (Braun & Clarke, 2006). Codes identify a feature of the data that is related to the research question. Codes are the most basic element of raw data that can be assessed in a meaningful way. In the current study, coding was performed manually. The researcher analyzed each interview by hand without the aid of qualitative data analysis software.

In phase three, the researcher sorted the codes and organized them into potential themes. A theme is an important aspect of the data that represents a patterned response within the data set that is related to the research question (Braun & Clarke, 2006). In the present study, a theme was defined as a pattern that occurred in 60 percent of the data and is counted as prevalence of participants who articulated the theme across the entire data set. Each theme was reported along with the number of participants who endorsed the specific theme in their interview. The percentage of participants who recognized each theme was included to demonstrate the fact that the theme was discussed amongst a number of participants. The themes were identified at a semantic level in which the themes were identified within the surface meaning of the data and the researcher was not looking for anything beyond what the participant had said. Analysis at a

semantic level follows a progression from description, in which the themes are organized to show patterns in content to interpretation, where there is an attempt to theorize the significance of patterns and their broader meanings and implications (Braun & Clarke, 2006).

Phase four involved reviewing and refining themes. Defining and refining themes means that the researcher will capture what each theme is about and will determine specific aspects of the data each theme describes. In Phase five, themes were defined and named. Defining and naming themes involved conveying the essence of each theme and choosing an appropriate name for each theme. In Phase six, the report was produced. When themes are worked out, the research tells a complicated story of the data in a concise, coherent and logical way. Following the analysis of the data sets for both Study 1 and Study 2, member checks were completed to ensure the validity of the data presented. Member checks involved emailing a summary of the results to those who participated in the study and asking for feedback regarding the degree to which the results accurately reflected their experiences. Participants were given the opportunity to provide researchers with their feedback in terms of the results of the study. Finally, the themes were compared between the therapists and the medical professionals. Similarities and differences between medical professionals and therapists were discussed in terms of the perceived influence of emotions on decision-making in clinical practice.

CHAPTER 3: RESULTS STUDY 1

Therapists' interviews were analyzed to determine the ways in which therapists perceived their emotions to impact the decisions in clinical practice. Following the analysis of therapists' qualitative interviews, five themes and various subthemes emerged (see Table 1)

Theme 1: Therapist-Client Interactions Impact Care (13/16)

Positive interactions between therapists and clients were found to evoke emotion in therapists that influenced their treatment decisions. Positive interactions were defined as the degree to which the therapists perceived the communication between themselves and their clients to be positive and collaborative. Two subthemes emerged: 1. Motivated and Likable Children Receive Higher Quality of Care, and 2. Positive Interactions with Parents Impacts Care

Subtheme: Motivated and Likable Children Receive Higher Quality of Care

The majority of therapists interviewed reported that the types of interaction that they engaged in with the child and the degree to which they felt the child was "likable" (pleasant or friendly), motivated (engaged in treatment), and "easy to work with" influenced decision-making. Some therapists reported that when they felt a positive connection, they were much more motivated to work with a "likable" child. For instance, therapists were more likely to fit a "likable" child into their schedule:

[When] the individual is very cheerful, having a really positive experience, you're more likely to react positively to that, be more open to fit the person in or talk to that person.

[...] We're just doing maintenance and checking in, she's quite happy and jovial and very large personality and very much enjoy working with her. [I'm] more apt to work with her or work around her schedule or just squeeze her in when you may not have squeezed someone else in (P1).

Therapists were also sensitive to the child and their struggles outside the realm of ED, which encouraged them to provide more support than they normally might have:

It's more her eating has resolved in many ways but because she struggles so much with sort of the social aspect of it and support, she requires a little bit more mentoring and so we try and provide that because we have such an affinity towards her (P2).

Therapists seemed to feel empathy for the children or sadness in response to the child's situation. There seemed to be something about a child in need that conjured up strong feelings of empathy in the therapist, especially when the child did not have the support from family. When therapists found themselves in situations in which the child was struggling, they seemed to take on a maternalistic role in which they tried to protect the child and provide the child with mentorship and a higher-level of support. This support was offered to children who were struggling even in instances in which the ED behaviours were in remission.

In addition to time and energy, some therapists spoke of dedicating more resources to a child who was motivated and consequently made them feel competent, even in cases in which lack of resources within the agency was an issue:

One girl who did a really awesome job turning herself around in terms of the eating disorder behaviour. [...] [She] has an underlying issue with anxiety, like crippling social anxiety and I mean technically, we're under resourced [...] so it's really difficult to justify carrying on treatment for something that could be treated somewhere else. [...] I want this kid to be successful and I can see a lot of myself in her. She's kind of this rebellious teenager but she's really introverted she thinks high school is a waste of time and so did I. So, now that we've actually created a relationship, I enjoy seeing her, I

really like her, and I want her to be successful so I don't know what those emotions would be named, but like, caring or warmth. (P3).

The previous quote also speaks to the fact that some therapists experienced countertransference with some of the child clients, which seemed to influence decision-making practices. In the current thesis, countertransference is defined as the therapists transfer their own emotional reactions to the child. When therapists could relate to the child on a personal level, they seemed to be fonder of the child and more emotionally invested in their success. The therapists spent time helping the child in areas in which the organization was under resourced because the therapist may have felt a sense of personal responsibility to do so.

Subtheme: Positive Interactions with Parents Impacts Care

Similarly to working with likable children/adolescents, therapists believed that when parents were pleasant, friendly, easy to get along with and committed to the treatment process, they were well-liked by therapists. Consequently, therapists perceived that they were more likely to allocate more time to motivated and likeable families:

Let's just talk about in terms of time spent: So if you've got a family that is engaged and working really hard [...] In terms of time, you would be at risk of giving them more time than a family that wasn't. And that would be driven by emotion because it's easier to work with them [when] you've got a fully engaged family, where in reality, it may be the family that isn't able to engage yet and has social determinants of health or barriers that need more time. And to me that would be emotion-based... so it's a simpler role (P4).

Most therapists reported that they preferred to spend time working with families who were pleasant and motivated. It seemed that if the therapist liked the family and felt that they were making progress with the family in treatment, they were more apt to allocate more time to

these families because they found the work they were doing easy, enjoyable and it provided them with a sense of satisfaction. Families who are motivated and putting in hard work toward the child's treatment would be more likely to be successful. Success achieved by the family may also be perceived as a reflection of therapists' professional abilities. As such, therapists would likely not mind putting in time with a family that is achieving success.

Therapists also believed that the positive interactions between themselves and families evoked feelings of warmth toward the parents influenced decision-making practices involved reticence to challenge the parents in therapy:

[We] try and keep our own frustration, you don't want to let emotions sort of sabotage the therapeutic relationship so I'd say that the therapeutic relationship is kind of put forefront. I think that for myself, sometimes I will not push as hard because I'm afraid that my relationship with the parent will be jeopardized. And there's probably times when I should have pushed harder (P5).

The fear of causing feelings of discomfort between parents and therapists was perceived to influence the intensity of therapy. Some therapists were more likely to avoid sensitive topics or deepening in therapy when there was potential to cause distance between themselves and the family. Although the avoidance of deepening in therapy may have made for more comfortable interactions between the therapist and the parents, it also could have hindered the treatment process because the parents may not have been challenged to implement certain treatment strategies at home that could have been helpful in their child's treatment.

It seemed as though the quality of care the child received could depend on the nature of the relationship between the therapists and the client/family. If the child or family was well liked by the therapists and motivated, they went above and beyond for them, even holding the child in

treatment longer than necessary to ensure that the child stayed on track with recovery. In some cases, however, some therapists reported that it is possible that the desire to increase the positive interactions between therapists and families could result in a less intense form of treatment if they also avoid potentially difficult topics.

Theme 2: Discharge (11/16)

Some therapists discussed that emotions such as fear or frustration influenced the therapists' decisions to discharge children with ED. Frustration was perceived to lead to decisions around early discharge. Interestingly, fear in therapists was found to result in prolonged discharge and holding on to child for too long. Consequently, two subthemes emerged: 1) Therapist Frustration leading to Premature Discharge, and 2) Therapist Fear leading to Deferred Discharge

Subtheme: Therapist Frustration Leads to Premature Discharge

Therapists reported that feelings of frustration in the clinician seemed to lead to early discharge for some:

I think discharging too quickly, giving up too quickly also. In the past I've seen that the client's not motivated, the client's not ready is often something that is said, and I would say that's more of a block. A clinician block, yeah. I would say it's... what is it that gets a clinician to blame the client? I don't know, like, frustration but I think fear too, like it's easier to blame the client than it is to blame yourself, right? (P9).

It seemed that some therapists described a tendency to blame the child/family and in some instances even pushed for early discharge. Rather than it only being one therapists advocating to close the file, it seemed that the team supported them in their decisions to

discharge in certain instances. Some therapists reported frustration when it came to the decision to discharge chronic cases as well:

With the enduring cases what I've found is again, as I say because sometimes there [is] difficulty to formulate and the same things might have been done over and over and over and there is a frustration. Sometimes, I'll tell you for sure, there's a push [from the team] to close their file. There is a push to stop working for change. It's more about 'oh maybe we should just give up on change and we can just look at maintenance' and I find that more often than not, people give up on hoping for change. [...] So there's frustration, there's impatience, there's some hopelessness on the part of the therapist, I think and the doctors and everyone else [who is a] part of the team. And sometimes I do see that going into, 'oh we can close the file and refer her to a community resource because we can't do anything more' (P10).

Chronic cases seemed to be particularly difficult for therapists because they spent a great deal of time and resources in their attempts to help these children/families. It was perceived as frustrating to the therapists that up until this point in the child's treatment, regardless of the time and energy they had put into therapy, the child's symptoms had not substantially decreased. In this sense, some therapists reported feeling as though they had failed the child because they were unable to help them progress through recovery. Some therapists had a difficult time accepting that their skills or therapeutic techniques were ineffective in certain instances. It seemed as though the therapists felt a secondary emotion of frustration, which resulted in unhelpful decisions, such as discharging the child/family:

I've had conversations with other clinicians where they've, you know, it seems more clear to me that it's really about the therapist doesn't feel good about the work that

they're doing with the client so they've recommended that therapy end or that they seek service somewhere else. So it's not clearly stated that way (laughs). I feel this way so we're not going to offer you service but it may be that a clinical decision is made based on that [the fact that they do not feel good about the work] (P11).

In particular, it seemed that when the therapeutic relationship was perceived as weak or therapists felt themselves "disliking" a client/family or finding a client/ family "difficult to work with", therapy delivery was reportedly impacted, such that therapists were more likely to discharge the child/family earlier than was required for their treatment. Some therapists spoke of instances in which negative feelings toward the children/families caused them to distance themselves from or even discharge them:

If this individual is, or this family or the child or adolescent, they're difficult to engage or to develop a rapport with, that again may influence the decision to maybe refer out to more intense treatment because, you know, they're just feeling, "well I don't know if I can work with this family effectively. Or I feel like you're just kind of spinning, I'm spinning my wheel, kind of thing" (P6).

By these and other accounts, it seems as though therapists believe that challenges in building a strong therapeutic relationship can lead to feelings of hopelessness in some cases. Therapists may feel as though they cannot help the child/family, which may lead to feeling as if they are not effective in their helping role. In fact, some therapists reported that they perceived negative feelings toward children/families as a contributing factor influencing client care. For instance, if therapists felt frustration toward a child/family, they may be more likely to be discharged:

You just got this sense that she [therapist] just didn't like her [client], and didn't like that she wasn't following through on things whereas a couple weeks after that she was, the same clinician was describing another case, who really sounded exactly the same. [...] As an outsider just looking into the cases, the cases sounded very similar and yet the decision on one hand, for one case was to discharge, and on the other was to really align [form a strong bond and partner with the client to progress through treatment] with the client and help them through that. (P5).

This quote illustrated the therapist's perception of the importance of others' emotions in regard to their ability to make decisions regarding treatment. While it is likely that other factors were also at play such as long wait lists, it is also possible that the participant observed that the therapist discharged the child/family due to frustration – whether toward the child/family or toward his or her self if they felt that they were not able to work with the child/family as effectively as they “should” have.

In instances in which there were negative feelings, such as frustration toward the child/family, some therapists felt as though they were not capable of working with the family. For example, therapists spoke of their own emotion being evoked by children with comorbid personality disorders:

When I get cases who on top of for the pure eating disorder stuff, there's also personality difficulties, with a personality disorder, or an emerging personality disorder, that can certainly affect me. [...] I find that really challenging depending on the way the personality disorder is affecting the relationship between myself. I do find that I want to push myself away from those clients. And I find them hard. And I think that comes from me not feeling like I really know what to do with them. Um, so a sense of not being good

enough or not being competent enough to help them mixed with like frustration as well. Frustration that they're not, that I don't quite know what how to reach them or frustration, that they're pushing back on something that I see as trying to be helpful for them (P7).

When challenging circumstance arose, such as those in which the child exhibited resistance, it seems that therapists believed that the therapeutic alliance failed to develop and their motivation and perceived ability to work with the child decreased. In the above description of a case encompassing comorbid personality disorders, child clients were perceived to be contentious, as they often disputed therapists' recommendations that were made in their best interest. Because these clients' symptoms were perceived by therapists to be difficult to contain, therapists often struggled with feeling a lack of self-efficacy and perhaps felt less competent as therapists.

Therapists also suggested that when the therapeutic relationship had not yet developed with newer families, when frustrations arose, they could be more likely to consider discharge. Therapists' perceptions of the ways in which frustration influences the decision to discharge in the case of newer families sheds light on the importance of developing a strong therapeutic alliance as well as the factors that may inhibit its development:

I think it's easier for me to feel frustrated with a client if I haven't gotten to know them really well. Clients that have been with me a long time, especially if we've both been working together; it's much easier for me [...]. I feel less frustrated if they have a setback [...]. [A] client where I'm just starting to get to know them and they're doing things like that then it's easier for me to blame [...] oh they're unmotivated, or that kind of thing. It's easier to become frustrated because I don't know their stories. If it's a new

client I would be likelier to give up pursuing them further. If it was an older client I would, that I've worked with before, I would try harder, especially if I felt they weren't making a lot of progress I would try harder to pursue them and find out what was going on. If it was a newer client I'd kind of say okay well if you're not ready, you're not ready (P8).

During the beginning stages of building the therapeutic alliance, therapists were much more likely to feel frustrated with the child's setbacks and seemed more likely to then conclude that the child-clients should not be in treatment. As therapists spent more time with children/families, the therapeutic alliance was strengthened. The data seemed to suggest that that when therapists felt more strongly connected to clients, they could be less likely to feel strong negative emotions toward the clients regardless of the situation.

When therapists disliked the client/family, they sometimes reported to have been refused care, either through discharge or referral. The therapists' perceived competence in certain situations may have also been at play, such that when the therapists felt confident about a particular case, they consequently invested more time and energy into that case, resulting in a stronger therapeutic alliance. If the therapists felt that a case was difficult or did not have confidence in their ability to treat the child/family, they may have avoided developing a strong relationship with the client and may have discharged the family as a means of avoiding feelings of helplessness, hopelessness or failure.

Subtheme: Therapist Fear Leads to Deferred Discharge

Participants raised the issue of fear in terms of the child-client's mental and physical health being compromised leading to a delay in discharge of the child - even when the child was

considered well. Therapists perceived that this fear often stemmed from being overly concerned for the child's health and well-being:

I have a hard time terminating with clients, having them leave the hospital, being discharged, and I'm very much concerned for the client's well being and don't give a lot of weight or attention to the more systemic decisions, and so some of my colleagues know that's my emotional angle, something that, my stance on things, and so that is going to make it hard for them to talk out about 'you need to discharge this person sooner rather than later'. So it's my emotions are coming into the decisions, but so are theirs (P12).

The therapists felt fear for the child's health because they felt a sense of responsibility to ensure the safety of their child-clients. It seemed that by refusing to discharge the client, the therapists felt that the client was safe, which also enabled therapists to reduce their own fear. The fear may have been with regard to the child's well-being in that they were medically unstable or would experience a relapse. Additionally, there was the possibility that discharging the child could impede or reverse progress that they had made with the child.

[They're] overly invested in the client and feels like they can't leave yet, 'they're not ready, they're not ready, and they're not ready'. Those are kind of the places where I think [emotion] gets in the way. I think because they know how detrimental an eating disorder can be, and so there is that sense of like, 'Is this child ready to go and like really, really in a place that they're well enough, and are they going to be supported well enough by their parents to be able to leave a structured environment and go back to school? And I think a lot of the time that does come from our fears and worries for that particular child...Yep (P13).

Therapists were invested in the outcomes of their clients and wanted to see their clients succeed. Some participants stated that clinicians may fear that if the child-clients were discharged, they might not receive the support that they needed to continue with their recovery. By making the decision to keep the child in treatment, therapists seemed to believe that they were protecting the child as well as regulating their own fears regarding the health and safety of the child-client. In addition to regulating fear surrounding health and safety, they were also reassured that the child was on track with recovery, which they may have felt reflected their competence as a therapist.

Therapists' own emotions or feelings toward a child/family can be a determining factor with regard to receiving treatment. Families who evoked fear in therapists received treatment above and beyond what is necessary and in some cases may have been held in treatment longer than required. Conversely, families who evoked frustration in therapists were thought to be more likely to be discharged, and sooner. The data suggested that therapist fear and frustration seemed to be reactions to their own feelings of low self-efficacy, such that frustration seemed to be masking feelings of being unable to help the child recover and fear seemed to be associated with trusting the family to implement what they have learned from therapy,

Theme 3: Resistance in the Family (16/16)

Difficult family dynamics were also reported to evoke fear, frustration and anger in therapists, all of which were perceived to negatively influence decision-making in clinical practice. Two subthemes emerged: 1) Angry/Critical Family, and 2) Noncompliant Family.

Subtheme: Angry/Critical Family

Every therapist involved in the study reported that when they were met with an angry family (a family that outwardly expressed anger at the child or the therapist), they struggled to

delivery therapy effectively. For instance, when presented with parental anger, some therapists reported that the fear of the anger affected their ability to deepen in therapy (going beyond the surface content to deeper issues):

I know that if a parent is angry with me, that scares me. I maybe don't speak the unspoken as often as I should. And I think that definitely plays a role in terms of my piece. So, I had a situation where I think a mom was very critical with her daughter and would be very, very angry with her daughter. And so, I would freeze instead of maybe saying to the mom, 'look at your daughter's response, look at how she's responding. You see what's happening right now?' And so in those situations when there's anger [...] I need to speak up and rise above those emotions and be strong and kinder and wiser in those in those emotions. And I find that sometimes it's very hard for me to do that. And I get blocked out of situations; it's really hard to work on (P9).

Some participants also noted that therapists' fear of anger also resulted in being more lenient around treatment decisions in order to diffuse the situation (e.g., therapists may be easier on an angry family in terms of their adherence to treatment and allow them to proceed to the next phase of treatment without completing the earlier phases):

The parents will become more angry or defensive with the staff in the program. I think that parents anger and criticism tends to influence clinicians more than anything. They're more likely to make decisions, you know, go out of their way to meet with the parents and try and figure out what would be more accommodating and often go against probably the clinical decision they made initially, especially with something like FBT. [They might not] move ahead with trying to get the child to eat more when it's causing the child a lot of anxiety; they might back off that decision. It's a bit of a chain, the parents are

impacted by the child's anxiety and the parents often are critical of the treatment or critical of the clinician and that causes the clinician to back off. I think [backing off is] possibly, its fear that they'll leave treatment or fear that they'll complain. I guess fear that they'll view the clinician as incompetent [or] complain to other professionals possibly about that. There might be a fear of embarrassment of being seen as not pleasing the client (P11).

When parents expressed anger, therapists reported feeling fear that sometimes caused them to freeze in response or accommodate the parents' requests in an attempt to avoid confrontation, reduce any negative impact on the child's treatment, and to ensure that parents did not act on anger impulses by terminating treatment. Not only did such decisions allow the therapist to avoid confrontation, it also enabled the therapists to avoid feelings of incompetence or judgement from other professionals.

Finally, some therapists noted instances where response to parental anger led therapists to deviate from standard protocol, such as manual-based therapies:

Yeah, they got a puppy in the midst of all of this and the girl was like maybe at 72% of her ideal body weight and they were wanting to take her out to go to the breeder to pick up the puppy and of course, it wasn't safe. And typically most parents are pretty good to recognize that, but again they discounted saying 'well it's only going to be for two hours, I mean really what could happen', and so we suggested they pick up the puppy and bring the puppy into the hospital, which they ended up doing and took pictures and what have you (P14).

This therapist also spoke to her colleague's experience with this particular case who reacted to the family's anger and demands by accommodating the family:

Our [therapist] who has worked with them longer; she's just been working through hoops and ropes because they'll leave many messages in the run of the day, only want appointments that are later in the day like at 5:00 or 5:30 because they're all involved with a lot of sports and a lot of things have been accommodated (P14).

The participant hypothesized that due to repeated demands of the parents, the therapists negotiated with them regarding the decision to receive a two-hour pass so that their child could see their new puppy and accommodated appointment times. She felt that the anger in the parents resulted in the clinician going outside of treatment protocol in order to reduce the parents' anger. It seemed that the therapist's reason for reducing the parents' anger was to decrease feelings of fear and discomfort in them, regardless of what therapists felt might be the treatment decision that was in the best interest of the child or the family.

Therapists' fear in response to angry parents may have been a result of their discomfort or lack of skill with de-escalation of strong negative affect. It is also possible that therapists may have feared that if they could not reduce the parents' anger, they would file complaints that could harm their reputation. To regulate their discomfort, it seems as though therapists were aware of a potential to avoid going too deep in therapy, negotiated treatment decisions, and accommodating requests in a way that they would not typically. If this was the case, although such behaviours may have appeased the parents and reduced the therapists' fears, the child may not have received optimal care as a result.

Subtheme: Noncompliant Family

Families who were noncompliant - in that they did not abide by therapists' treatment recommendations - seemed to evoke emotion in therapists that affected clinical practice. When some therapists were met with a noncompliant family, they reported feeling frustrated, which

influenced communication style and decision-making. In some examples, therapists described feeling most frustrated when parents seemed to be aligning with the child's eating disordered behaviour rather than adhering to the therapists' treatment recommendations. When parents accommodated their child's ED behaviour, therapists noted tendencies toward a negative style of communication:

She [client] was very explosive and very angry; angry at everything and the family was very passive. [They were] very afraid for her health. She would be very demanding [about] what to eat and what not to eat, [saying], 'this is what I have, you need to buy me this'. And the family was continuously buying into [it] as opposed to kind of taking our suggestions of taking a step back [and saying], 'Okay, we can't fall [into this], we can't listen to the ED [...] we want the individual to be better'. So the family was not following through with what they had stated they were going to do. [...] It became pretty frustrating and I think this would also influence the decision making if it wasn't influenced by the interactions. We had to become very blunt and very direct and say, 'listen this is not helpful and this is'; really lay it down clearly and very bluntly that this is making the eating disorder get worse, which means the healthier child is getting worse. This is not a helpful behaviour as opposed to trying to encourage the family to come up with decisions with gentle pushes and pulls in different ways (P1).

This therapist also suggested that therapists' frustration occurred when the parents did not seem to be acting in a supportive manner:

In circumstances where, (sighs) like for example, the parents are not helpful, they're not following through with protocols, they're not making the time for the child, they're coming in for their appointments, but other than that they're not doing [what the team

suggested] even though they say they're going to and that becomes very frustrating. [It becomes] frustrating for both clinicians because we know that's not in the best interest of the client. We're taking this time; we're spending this time with them and for what? They're like for example, family that I'm thinking of [...] they're very adamant and very frustrated if we had to reschedule or if we had to make any changes [or] if they couldn't get in right away. Yet they weren't doing the work, so [there is] lots of frustration there [and] it may [affect decision-making] (pause) we may be less likely and less flexible to rearrange our schedule to fit them (P1).

Some therapists reported frustration in the face of non-compliant parents' refusal to implement agreed-upon interventions at home which some felt reduced the impact of the time and energy already invested. The frustration may have come from the fact that the parents directly opposed their treatment recommendations and possibly increased the potential risk to the child.

Finally, therapists shared examples when they felt anger towards the families of very ill patients who were in denial of the extent of their child's illness. This anger toward the parents may have stemmed from a genuine concern and sadness for the child. This anger was reported to have a negative influence on the clinicians' behaviour, including in session, such that therapists would openly express their anger toward the parents:

Actually the thing I find personally most difficult to work with [...] it's when parents don't see the severity of their child's illness and that the[y] [are] reluctan[t] to take the advice of the team. Those are the ones that really, really, really are frustrating; heartbreaking [...] I do think that's a time when our team tends to get angrier with the parent though. I'm thinking of a family that I didn't work with directly but another

family therapist who's usually able to kind of leave that stuff at the door did and her reflection was 'I'm getting angry with them in the session and I wouldn't ordinarily be', that's not in her character (P13).

Therapists reported that when parents were noncompliant with treatment recommendations, they struggled to remain neutral and objective. It seemed that in situations in which parents were noncompliant with treatment recommendations, therapists struggled to feel empathy for the parents. Therapists seemed to become frustrated with them and even place blame on the parents, perhaps overlooking the possibility that such parents were acting from a place of fear. Participants reported that in some cases, the frustration felt by the therapists directly impacted treatment delivery, such that therapists became angry or short with families in therapy and were less likely to fit these families into their schedule. If parents are on the receiving end of therapist frustration, it is possible that parents could then feel increasingly misunderstood, unsupported and thus less likely to engage in recovery-focused behaviours.

Theme 4: Level of Clinical Experience (10/16)

Some participants reported that clinician experience seemed to influence the degree to which emotion influenced therapists' decision-making practices. Therapists perceived that new therapists lacked confidence and competence in situations involving strong emotions. Therapists suggested that more experience or training lead to more objective decision-making in clinical practice. For example, therapists reported being more affected by their own emotions when they first began their career:

I have worked enough with families and couples to tolerate strong emotions in the room and not personalize it or take it personally. I remember when I first started that was a little bit emotionally harder for me to tolerate. You feel like 'I need to do something' but

not knowing yet what you're going to be doing or feeling ineffective at that time. Over time you get used to the population and understand that there's less unexpected and you know what you need to do, and feeling a little bit more competent helps. Um it's the bulimic population, their emotions are more dysregulated, impulsivity, and emotionality, is something that I think in the beginning you have to get used to, that piece of the session [...] With experience that apprehension piece disappears, like you learn what to expect from the session and you feel competent that you can manage whatever happens to come up (P12).

Therapists believed that experience came with exposure to emotionally charged situations. Their belief was that due to lack of exposure, the novice therapist might not have been adequately prepared (competent) to deal with the emotionally charged situations. Some therapists felt that those with less clinical experience had a more difficult time processing their own emotions as well. In particular, therapists perceived that inexperienced therapists changed their treatment decisions based on their emotional reactions to certain situations in therapy. For example, if the inexperienced therapists were in a situation in which the child/family felt a strong emotion, they may agree with the client's feeling rather than critically examining the clients' thoughts and feelings and challenging the client to move away from unhealthy behaviours.

One therapist described an instance in which one of her students changed her decision-making based on her emotions:

It happens a lot especially with training new people. [...] One of my students she is very agreeable and very happy, but when the client starts talking she starts getting sad, she would become more agreeable with whatever: 'oh ya you should do that', as opposed to looking at it more critically. [She is] just going with what the client is saying even though

some of those thoughts may need to be challenged. Okay so being less kind of critical of the eating disorders symptoms (P1).

When inexperienced therapists were met with new or challenging situations, therapists perceived that the inexperienced therapists felt a sense of inadequacy that lead them to be unsure of their decision-making, which resulted in going along with the family's recommendations. For instance, one therapist said:

It feels like the perception that [clients are] like, 'why are you telling me what to do when you're so much younger than me?' and that's not always it but sometimes there is that kind of the perception from the parents. It probably makes me a bit more tentative [when it comes to decision-making in clinical practice] (P8).

A therapist also described that discomfort with emotion in younger therapists may cause them to depend more on prepackaged programs (step-by-step programs that have been designed to treat a specific issue without taking into consideration the client's unique circumstances). For instance, a novice therapist may experience anxiety or fear when emotions come up in therapy. Rather than rely on their own knowledge and skill to help process emotions with clients, they may instead focus more heavily on a prepackaged program, regardless of its relevance for the presented issue:

Of the other colleagues that I have [...], she's young, just starting out so she tends to use a lot of prepackaged programs whereas I can counsel and tend to match the client. So that style of therapy [the inexperience plays a role]. There's a huge, to me there's a huge difference between a young worker and a seasoned worker (P15).

Therapists felt more comfortable relying on pre-packaged programs because they may have felt inadequate in their ability to direct a therapy session. Knowing that they had a program

to fall back on may have reduced amateur therapists' anxiety in treatment delivery. Some therapists felt that they were better able to manage their emotions as they gained experience working in the field. Participants were of the belief that the more time therapists spent working in the field, the more they became exposed to emotionally charged situations. Exposure alone may have increased therapists' comfort with sitting with their own emotions. It seemed that the more at ease therapists felt when they experienced uncomfortable emotions, the less likely they were to act in a way to reduce their own discomfort, which lead to a reduction in emotionally based decisions.

Theme 5: Factors that Protect against Emotional Influences on Decision-making (16/16)

Although therapists suggested that emotion is always present in clinical practice, all therapists discussed factors that helped to protect against negative emotional influences on decision-making. Two subthemes emerged: 1) Self-reflective Practices, and 2) Team Support

Subtheme: Self-reflective Practices

Therapists discussed the importance of using self-reflection (thinking about one's reasons for their thoughts and actions) as a means of becoming aware of their own emotions in the context of clinical care. Engaging in self-reflection was perceived to enable therapists to prevent their emotions from influencing clinical decisions:

I try to teach clients [that] the less you're aware of your emotions and know what role they're playing the more dangerous it is for you, I think that's the same for a clinician. No matter if it's your own emotions [or] whatever is going on in your life or if it's the emotions to the circumstances that you're being faced with, I think if you're not aware of them and know the power of them or try to become aware of them, (pause), it's pretty dangerous. You're going to make decisions and you're not going to be taking in all the

facts, you may not take in all the facts, they may be shaped by your emotions which may not be [pause], the best decision at that time (P1).

By being aware of their own emotions in clinical practice, therapists were better able to prevent emotionally based decisions that have the potential to negatively influence clinical practice. It was suggested by some participants that personal therapy could enable therapists to develop self-reflection skills. By understanding their personal issues, they could better recognize and understand their triggers, and thus be less likely to act on emotion. Some participants also raised the point that emotions in practice are not necessarily negative, but that awareness is needed for discernment in the context of clinical decisions:

See, there's a reason why traditional therapy training for therapists involved some kind of self-reflective process, or you know, for the interns going through psychoanalysis. [...] that whole sort of being aware of your own issues and really understanding. [...] And so I would say professions where that is built into the training probably, I would hope are in a better position to manage emotional decision-making. [...] So it's not like emotions are bad, it's just, 'is this coming from an accurate assessment of the situation, and should I really pay attention to these emotions?' Or 'is it coming from some issues that I have', right? And therefore, if I listen to them, I'm acting out those issues rather than in the best interest of my patients (P7).

Engaging in personal therapy was reported to be an important component of self-reflection because psychotherapy brings to light all of the issues in the therapists' own lives that have the potential to evoke emotion and subsequently influence therapists' ability to deliver treatment. By becoming aware of these issues and the emotions that were aroused in relation to the issues, therapists were in a better position to recognize when their own experiences and

emotions were beginning to influence the delivery of treatment. Emotions were perceived to have a place in clinical practice and could be helpful when the therapist was aware of their emotions and the ways in which their emotions could influence their decision-making in clinical practice. Therapists reported that self-reflection - especially through engaging in personal therapy - heightened their awareness of their own emotions and their influence on their work.

Subtheme: Treatment Team

All therapists spoke of the importance of having a supportive treatment team to mitigate the influence of clinician emotion on clinical decisions:

I think we often have to manage emotions of team members (laughs) you know, that's part of our working relationship as a team. If we notice that somebody is being overly influenced by their emotional state that day, we will work as a team to regulate that. For instance [...] We would sort of say okay well, you know, the [medical professional] is having a bad day that day, maybe we'll revisit this decision another day when she's in a different state of mind. We sort of work together. And that would be the same if another therapist noticed another one of the therapists was feeling overly emotional or that they felt they were triggered by a client. We would talk about that as a team and try and make a good clinical decision, like a balanced clinical decision (P11).

Therapists reported that being a part of an accepting and empathetic team allowed team members to openly talk about emotions and to provide feedback regarding potential treatment decisions. Most therapists also described the importance of having a team environment that focused on emotion regulation and decision-making:

We talk through things a lot so I think that when we make a decision we've actually had a lot of time as a team to process what kind of decisions we want [to make] or what kind

of steps we want to take. So I think in some ways our emotions are kept in check because we have a lot of regulators before we get to implement the decision. If there's like a big decision to make, we're talking about it a lot with the team and so if you have ten people batting around an idea, even if you personally have a really strong emotion about something, you have a bit of a balance and a time to process that before [acting on that decision] (13).

Finally, therapists spoke about the importance of consultation with colleagues in reducing emotionally charged decision-making:

I think the opportunity to just consult with your colleagues is so important because I think that can really be a great stabilizing influence. So, you may have just had a session with a really challenging or difficult family and I think just having the opportunity to process it can help put things in perspective and maybe help you kind of view the patient a bit different or to maybe help you have more compassion towards them or maybe have more patience with them. [...] I think it just heightens everyone's awareness that this is maybe a difficult family, a challenging family that's stirring up emotions and it's just kind of underscores the need to really be aware of any biases that we may have. Maybe to talk to each other about that, like, what's being triggered in us by this patient or this family and sometimes it helps when your colleague is not as involved with the family therapeutically just to kind of help to take a step back and objectively look at things (P7).

Therapists shared that emotions were present in clinical practice and it was important to be able to process emotions when they were evoked. Being able to openly discuss emotions with the team enabled therapists to process their emotions and understand the root of their emotional reactions. Team members were often able to provide therapists with a different point of view on

the situation and help ensure neutral decision-making processes. Therapists perceived that team discussion around the prevention of emotionally based decisions seemed to increase the likelihood that treatment decisions were made in the best interest of the child/family.

Table 1

Theme	Emotional Processes	Clinical Decisions Influenced
1. Therapist-Client Interactions		
<i>A. Motivated and Likeable Children</i>	Warmth	More time, energy and resources allocated to child-client's treatment
<i>B. Interactions with parents</i>	Fear of rupturing relationship	Inability to deepen in therapy
2. Discharge	Fear	Prolong Discharge
	Frustration	Discharge Early
3. Resistance in the Family		
<i>A. Angry/Critical Family</i>	Fear	Accommodate client/family
<i>B. Noncompliant Family</i>	Frustration	Less flexibility; less likely to fit in schedule; blunt or critical style of communication
4. Level of clinician experience	Fear/anxiety	Vulnerability to emotional influence on treatment decisions
5. Protective Factors		
<i>A. Self-Reflective Practices</i>	Increased awareness of emotions	Lower vulnerability to emotionally based decisions
<i>B. Treatment Team</i>	Increased recognition and processing of emotional experiences	Lower vulnerability to emotionally based decisions

Discussion Study 1

The results of Study 1 suggest that therapists perceived an influence of emotion on their ability and the ability of their colleagues to make sound decisions in clinical practice at least some of the time. For instance, it seemed that the nature of interactions between child-clients/families and therapists influenced the quality of treatment that the child-client/family received. For example, when therapists felt they had positive interactions with their clients, they were more likely to accommodate to the family. If the interactions between child-clients/families were strained, therapists were more likely to be referred or discharged. In fact the influence of emotion on the decision to discharge was a topic that was raised numerous times by most therapists. For example, when therapists felt frustration or anger with the child/family, they reported being more likely to discharge the patient earlier than usual. If therapists felt fear for the child's wellness, it seemed to decrease the likelihood of discharge – even when appropriate - in case the child could not maintain wellness outside of clinical care.

In terms of therapist' feelings toward a family in treatment, it was reported that when the family's anger was interfering with therapy, therapists felt frustrated and afraid. As a result of their fear and frustration, therapists observed in themselves and others a tendency to accommodate and negotiate previously agreed- upon treatment decisions or to avoid booking the family for therapy.

Therapists' level of experience was also perceived to impact treatment delivery. Therapists reported that it seemed that therapists with less experience were more vulnerable to the influence of emotion on treatment decisions. With time, therapists were thought to be better able to process and regulate their emotions in clinical practice, which they perceived resulted in

more objective clinical decisions. Finally, therapists discussed the importance of self-reflection and open discussion with treatment teams as a way to recognize and process emotions to reduce the negative impact of emotion on treatment deliver.

The present study revealed a number of interesting findings that contribute to our understanding of the ways clinicians perceive the influence of emotion in the delivery of treatment of child and adolescent ED. Brener et al. (2012) identified that when working with ED in clinical practice, emotions such as frustration, fear and insecurity commonly arise in therapists. The present study sheds light on the ways in which therapists perceive the impact of these strong emotions in their practice.

For instance, therapists perceived that when clinicians struggled with interacting and connecting with child-clients/families, it evoked frustration, which they felt could lead to early discharge. This finding sheds light on the fact that it is necessary that therapists understand the importance of developing a strong therapeutic alliance as research suggests that it leads to more optimal treatment outcomes (Owen, Reese, Quirk & Rodolfa, 2013; Safran Muran, & Eubanks-Carter, 2011; Sloan & Owen, 2015). Bordin (1977) described the therapeutic alliance as having specific components. For instance, the therapeutic alliance was reported to be composed of a patient who wishes to change and a therapist who helps to facilitate change. The therapist and client have a mutual understanding or agreement regarding the goals for change and the tasks that need to be accomplished in order to reach these goals. In addition, the therapist and client must have the ability to establish bonds to maintain the work together.

It is important that therapists be made aware of the potential impact that these emotional processes can have on clinical decisions so that they do not act impulsively and discharge, when the factors interfere with the development of the therapeutic alliance. In the case of ED,

therapists must be aware that the therapeutic alliance may be slow to develop. Ultimately, research suggests that each component of the therapeutic alliance may be affected by ED. For instance, establishing a therapeutic alliance with patients diagnosed with AN is challenging for multiple reasons, such as fear of change and development, perceived defiance on the part of the client, negativity that expresses an underling sense of helplessness, the investment of AN as a primary identity, denial of the problem, and impairment cognitive functioning due to malnutrition (Pereira, Lock, and Oggins, 2006; Couturier & Lock, 2006; Katzman, Christensen, Young, & Zipursky, 2001;). If individuals with AN are resistant to treatment, it makes sense that the therapeutic alliance would be affected, as it may seem that they do not want to perform tasks that lead to a common goal set by themselves and the therapist. Additionally, individuals with ED may have difficulty developing a strong and trusting bond with therapists based on previous relationship ruptures. While frustration was perceived to lead to early discharge in therapists, there is the possibility that the tendency to discharge had less to do with a dislike for the client or a way to protect their reputation, and more to do with pressures placed upon them by the increasing number of individuals presenting with ED and seeking treatment.

The results also relate to Waller's Therapist Drift Model (2009), such that it seems to provide some evidence for therapist drift. Waller and colleagues (2016) identified three elements for therapy to be effective, one of which was the need to deliver evidence-based treatment in adherence to protocol. Results of the current study shed light on the fact that therapists who experience high emotional arousal may not adhere as strictly to treatment protocol and as such; the child/family's treatment may be negatively impacted. Kosmerly et al. (2014) also provided evidence to suggest that high anxiety in therapists resulted in less adherence to treatment protocol in the treatment of child and adolescent ED. The results of the present study provide

further support for the results of Kosmerly et al. (2014) study, adding that in situations when therapist emotion was high, therapists reported lower adherence to standard or previously-elaborated therapeutic protocols. For instance, frustration evoked by a noncompliant family was perceived to influence therapists' communication style. Rather than following the recommendations in the FBT manual, which suggests working to empower and support parents to play an active role in the treatment of their child's eating disorder, it was thought that therapists communicated with the parents in a blunt and critical manner.

The results of the present study also expanded upon the results of Lafrance Robinson and Kosmerly's (2015) study, where one of the main findings revealed that the category of decisions most influenced by emotion was the involvement of the family in therapy (in particular the inclusion of a critical or dismissive parent in therapy). In the current study, although we did not collect data on which emotions were most charged, all fourteen of the therapists participated in the study commented on this phenomenon in that in response to critical or angry parents, therapists were perceived to be more likely to deviate from protocol.

Therapists also perceived that positive experiences with treatment teams and self-reflective practices reduced the negative impact of emotion on decision-making. These results are in keeping with the results of a study by Dieleman et al. (2004), which suggested that a cohesive team was important for treatment of complex cases. In the present study, therapists reported that when they experienced positive relationships with other members of the treatment team, they are able to express their emotions to the team and receive guidance and feedback regarding treatment decisions. While there is a possibility that having a good working relationship with colleagues and an open team environment may reduce the influence of emotion on decision-making practices, again, other possibilities may also be likely. For example,

Lafrance Robinson and Kosmerly (2015) found that in a sample of clinicians in which the majority was part of a treatment team, emotions were still perceived to impact treatment decisions.

The results of the present study and Lafrance Robinson and Kosmerly's research suggest that a team approach does not always result in effective or appropriate decision-making. One possible explanation is that while therapists are comfortable bringing their emotions to the team and may have their emotions validated by their team, the process may not go any further and the team may not make suggestions or interfere with the therapists' final decisions. Alternatively, there is the possibility that treatment teams are engaging in groupthink (Janis, 1972). Groupthink was described as extreme concurrence seeking tendencies in decision-making. Groupthink was thought to be detrimental in effective decision-making because the need to act in union with the group becomes so dominant that it tends to override the realistic evaluation of alternatives to a decision (Janis, 1972). Perhaps therapists value the cohesion they experience with their treatment team and their feelings to remain in good standing with their colleagues subconsciously clouds their ability to develop and put forth alternative treatment decisions. In these cases it may be beneficial for a third party or secondary consultation team to ensure groupthink is not interfering with the ability of the team to offer guidance. It may also be beneficial to offer team members the opportunity to anonymously offer their suggestions and opinions on certain matters without the influence of other team members.

As mentioned, it may be helpful for programs to develop safe guards to ensure that inappropriate discharge or other emotionally based decisions do not occur. Such safe guards may include an analysis of emotional reactions felt by the team. If team members are not neutral and are experiencing strong emotions that may influence decision-making, it may be helpful to bring

in a secondary consultation team to ensure that emotions are not negatively influencing client care. The role of the secondary consultation team would be to evaluate the decision-making practices of the existing treatment team. Because the secondary consultation team would not have contact with the clients or families and would not have an emotional connection to these cases, they may be in a more favourable position to ensure that the decisions being made were in the best interest of the client and were not influenced by other factors, such as team members' emotions.

It is important to take into account that the current study examined therapists' perceptions and so we cannot make definite conclusions regarding the ways in which emotions influenced decisions in actual practice. For example, in the current study, therapists perceived that with more experience in the field, both themselves and their colleagues were less likely to allow emotion to influence clinical practice. Although this may be true, other possibilities are also likely. For example, Wilson and Ross (2001) tested a theory of temporal self-appraisal by examining individuals' evaluations of their current and former selves and found that people evaluate their distant past selves as less favourable than their present selves. In other words, they tend to rate themselves as better in the present when compared to their past selves. As such it is possible that clinicians reflecting on the impact of experience on emotion-based decisions in clinical practice are experiencing a temporal self-appraisal bias. Of course it is also possible that both factors may be at play making it difficult to ascertain the true impact of personal experience on the intensity of the experience of emotions and its impact on clinical decisions.

Overall, the results of the present study provide evidence to suggest that therapists perceive their own emotions and the emotions of their colleagues' impact treatment decisions. A number of suggestions were made to reduce the negative impact of emotions on decision-

making, such as ensuring that therapists are made aware of the slow process of developing therapeutic alliances, bringing in a third party or a second consultation team to oversee decision-making, and allowing therapists to make anonymous comments and suggestions to ensure that groupthink does not occur. More research is needed to determine the effectiveness of the suggested safeguards as a way to reduce the negative impact of emotions on clinical practice.

CHAPTER FOUR RESULTS: STUDY 2

Where as study one revealed important information about the ways in which therapists perceived their emotions to impact their decision-making practices, study two poses the same research question in medical professionals. It is necessary to research the ways in which medical professionals perceive their own emotions to influence practice because therapists and medical professionals usually work together as part of a treatment team in the treatment of child and adolescent ED. Following thematic analysis of qualitative interviews with medical professionals, four themes and six subthemes emerged relating to the emotions evoked in the medical professionals as well as their influence on clinical decisions (See Table 2).

Theme 1: Fear of Harm to the Child (5/5)

All medical professionals reported experiencing fear related to the potential for the risk of harm to the child. When medical professionals felt fear or perceived fear in their colleagues, they seemed to take action both for safety's sake as well as a regulatory mechanism. In other words, not only did this ensure the medical stability and the safety of the child, but also served to regulate or reduce the fear in medical professionals. Two subthemes emerged: 1) Fear associated with medical instability and hospitalization of the child; 2) Fear associated with self-harm and suicidal ideation in the child.

Subtheme 1: Fear associated with medical instability and hospitalization of the child

Medical professionals shared that when their child's health began to decline or when the child's life was at risk they were more motivated to work quickly to order necessary tests. This fear motivated the medical professionals to make more of an effort, perhaps in order to reduce the discomfort of their fear:

When I'm meeting a young person and their blood pressure is very low or their pulse is very low, that concerns me that they're at risk of death. I order blood work and I order medication and different things, so [I'm] just more and more motivated, by you know by concern if potassium is low, I want them to have a supplement because their health is at risk. If their B12 is low, or they're anemic, I want them to have supplements because, you know, they're at risk [...] so again, I guess some motivating factors is overall concern for the client (P1).

Medical professionals also spoke of fear influencing motivation to go above and beyond by means of exerting more time and energy on a patient who was declining. Fear was associated with protecting the child from further medical decline and/or death. Medical professionals described the fear as being so intense in some instances that it seemed to consume various aspects of their lives: "When I first started, a lot of it was fear based. So oh my god, I'm so afraid, I'm so worried. They were in my dreams, they were in my thoughts, I talked about them a lot" (P4). The fear evoked in medical professionals seemed to have caused them to make decisions based on preventing medical decline in the child. For instance, medical professionals dedicated more time and resources to a child who was medically compromised. This fear-based decision-making seemed to be a combination of genuine concern regarding the health of the child and a means of reducing their own fear associated with having a child become further medically compromised or die while in their care:

My clinical decisions were really based around my fear for them so like I didn't want them to get any sicker [...] So if I kind of get worried about them, then I see them more often or I'm contacting [specific medical professional] more often or I'm talking to the

[clinician] more often. I find I'm looking for more solutions. I'm looking for something concrete (P4).

This phenomenon was noted more often with AN clients who were perceived to be more medically at-risk:

The person with anorexia and their restricting behaviours and how quickly the person can decompensate, might motivate a clinician a little bit more because they're more concerned about that person being compromised and being ill really quickly and maybe having their life at risk (P2).

Some medical professionals described their experiences with the ways in which their anxiety around medical stability of the child influenced her clinical decision-making. These medical professionals suggested that the anxiety felt around critically ill patients with AN motivated them in that they sought out advice and reassurance from other members of the treatment team. In such instances, the medical professional allocated more time, paid extra attention to detail, and sought out other resources to ensure that the decisions made were in the child's best interest:

I think more anxiety can be brought up in the position particularly around the really unwell patients with anorexia, who are so low weight and might be more at risk for sudden adverse events, you know, such as death. [...] In the past, I've felt particularly worried about a patient; you know that something might happen. Me being the [specific medical professional] and you know, the one that would be ultimately responsible for her care, I guess maybe making sure that I had, you know, full involvement of the rest of the team, you know get a second opinion from the [specific medical professional] on the team, [to determine] if I was on the right page with things or that I was responding

appropriately to the situation that was happening kind of looking to the rest of the team to sort of oversee it (P3).

Interestingly, some medical professionals spoke of how being ultimately responsible for the child lead to fear that they would appear incompetent if their client's health declined while in their care. In this case, validation from the team and allocating more time and resources to the child seemed to serve as a mechanism to regulate the medical professionals' own anxiety. Medical professionals may have also felt particularly vulnerable to the influence of this anxiety on their decision-making processes in child-clients with AN because the medical instability was often more visible in their underweight figure than in child-client's with bulimia, who perhaps weren't or didn't appear as ill – at least outwardly.

Subtheme 2: Fear associated with self-harm and suicidal ideation in the child

Medical professionals described that they also felt anxiety in response to self-harm behaviours and suicidal ideation in their child-clients. As in the case of medical instability, when anxiety arose in the medical professionals, it seemed to motivate them to intervene with urgency to ensure the safety of the child: “An adolescent who has a low mood, is expressing self-harm actions or suicide actions. I think that's where that kind of risk of emotion gets put into play. Um, maybe more time is invested, more resources are utilized” (P2). In such cases, medical professionals seemed to act not only to ensure the safety of the child, but also to reduce their own fear of the child's death. Fear in medical professionals also seemed to be associated with feelings of responsibility for the wellbeing of the client and the medical professionals seemed to feel incompetent or ashamed when their efforts in treating the child were unsuccessful.

Medical professional also reported that self-harm or suicidal actions in the child motivated immediate intervention:

If you have a child that comes in and are telling me they want to commit suicide, of course, that concern of what might happen to them and them actually following through motivates me to make sure they go to the hospital for assessment [...] If I'm concerned something is going to happen to them, that would motivate me to get them the help they need (P1).

They also discussed that suicidal ideation seemed to arouse the strongest emotion which acted as a motivator to promptly get the child help:

Suicidal ideation. So the depression or anxiety would motivate more of the decisions. So if a kid is saying they're suicidal and they can't contact or say they won't do something or they won't tell their parents or they won't promise to come back then that's a motivator because you are concerned to get them looked at [...] Their decision making is to get them help (P1).

It seemed that fear associated with self-harm and suicide was a natural response because there was a life at risk and the medical professionals felt a responsibility to protect that life. The fear-based decision of responding with urgency and utilizing various resources also seemed reasonable. However, medical professionals may have also acted as a means to reduce their own feelings of anxiety in terms of being viewed as incompetent if their child's health declined. In this case and also when clinicians report ruminating about their child's health, the influence of emotions did not necessarily have a negative impact on decision-making in clinical practice although it did appear to impact on the clinician's quality of life. This subtheme supported the notion that strong emotions arise and can pose challenges to these clinicians when working with child-clients who exhibit self-harm and suicidal ideation.

Theme 2: Team Dynamics (5/5)

All medical professionals indicated that the dynamic of the treatment team influenced their emotions, which in turn influenced clinical decisions. Medical professionals agreed that when they had positive interactions with the team, characterized by respectful and supportive collegial relationships, they were better able to recognize, understand, express their emotions to the team, and in turn, the team played a positive role in reducing the influence of emotions on clinical decision-making. Conversely, if the medical professionals reported a negative experience with the treatment team, that is, the treatment team was seen as unsupportive, judgmental, or they were engaged in conflict with team members, the clinicians still reported experiencing emotion, but did not feel comfortable going to their colleagues for support and guidance, therefore potentially increasing the risk of biased decision-making.

Subtheme: Positive Experiences with Treatment Team

Medical professionals expressed the importance of working as a part of a multidisciplinary team, as positive feelings toward one's treatment team were reported to be protective against emotionally-based decisions. Medical professionals described the ways in which positive experiences with the treatment team lead to a perceived decrease of the influence of emotion on clinical decisions:

We're lucky we have a team meeting every week, so we're able to bring cases forward.

And if a clinician is feeling a bit frustrated or not sure what else they can do to try to engage someone or to make changes or whatever it is, we're able to talk about that in our team. We're a very small team and to come up with ways to support each other on other ways and things to try (P1).

Medical professionals reported that the team served to buffer against emotionally-based decisions in clinical practice. When clinicians felt strong emotions, they brought these emotions

to the team and rather than acting based on their immediate feelings, they were able obtain advice from team members who were not emotionally activated at the time. A medical professional spoke about the ways in which bringing emotions to the team buffers against emotionally-based decision-making in clinical practice:

We talk about emotions, we talk about how we're feeling and how we talk about frustrations or I think [for example] one clinician discharged five people in one week and had five people cry and it really emotionally drained her because she was feeling terrible for having discharged five people, even though she knew that they were well enough to carry on, and they really didn't need to be here anymore. So we do talk about [emotion] which is great, um lots of validation. Weekly meetings [are an attempt to reduce the negative influence of emotion on decision making]. We talk about that and kind of help reframe things, validate how the clinician is feeling, and sometimes when things are really difficult, they're having a hard time. Meeting as a group to kind of problem solve other ideas, other options that maybe the clinician is not considering. I'm very lucky, this is a really, really good team (P3).

For instance, one medical professional described that being part of a positive multidisciplinary team rounded out the education received (which focused largely on medical care) so that he was better able to manage emotionally charged interactions with patients:

The longer I've had the opportunity to work in this field the more I feel that I benefit from working with my colleagues who have more background in mental health training to be able to recognize, you know what my emotional responses are and to also learn techniques that they use in order to validate the emotions that patients and families are bringing with them into the clinical encounter (P3).

Participants reported that it was important for the treatment team to be respectful in the sense that they were considerate of other team members' emotions and realized that emotions were a human experience – and more likely to occur when working with ED. It was also reported to be important that the treatment team be perceived as supportive in that they did not show judgment and rather displayed a genuine desire to help other team members work through emotional experiences.

Subtheme: Negative Experiences with Treatment Team

According to participants, negative experiences with the team seemed to decrease the frequency of support-seeking behaviours and therefore may have influenced the extent to which emotions influenced clinical care. Medical professionals discussed the ways in which factions in the team affected the team members as well as their clients:

I've seen where there has been a real attempt to sort of align with the patient and scenarios where there's been more alignment with the illness. And when that happens you're meeting together as a multidisciplinary team and feelings [arise such as] defensiveness, anger, feeling like that person is being personally attacked with respect to how that patient is or how they're approaching therapy in that situation. (P3).

One particular medical professional also discussed the ways in which the program was in the process of changing treatment models which lead to an increase in anxiety among team members as well as divisions in the team:

Some members of the team have responded by taking sides and a real sort of division of cohesiveness of the team as opposed to kind of all wanting to get to the same point, sharing common goals and working together. Unfortunately, there has been poor access

to elements of care within the team [...] where it's actually started to limit new assessments or referrals (P3).

As such, the anxiety around the new treatment model leading to division of cohesiveness in the team has directly affected clinical practice in that children/families are not receiving the care that they need.

Medical professionals also discussed the ways in which they observed negative emotions resulting from tensions with other team members to result in refusing care for a patient:

I think when the team is an unhealthy team, that's when the emotions really come into play because unfortunately, I find that sometimes other clinicians can use the anger or other negative feelings towards other members of the team. I guess the client becomes the object of communication for some of the negative feelings like if the team can't communicate effectively amongst themselves. Very sadly, I think that the emotion is worked out through the patients and that is very dangerous (P5).

When asked to give an example, the medical professional responded:

If my colleagues were angry at me that I wasn't completing my workload, they would refuse to admit a patient that I was closer to than they were based on my recommendation. They would refuse to assume care of a patient if they didn't agree if they were angry at me or uncomfortable with a treatment decision that I had made (P5).

Medical professionals reported on the ways in which conflicts with other members of the team were perceived to create anxiety in the clinician, causing them to revise treatment recommendations - and in one case consider excluding a member of the treatment team from discussions:

I find every time their reaction or lack of reaction makes me afraid to want to pick up the phone and call them the next time. I find I am having to help myself through it and say, ‘Okay, put on your big girl/boy shoes and still do it’. The work is hard enough; you don’t need that on top of it (P4).

This medical professional also spoke of the ways in which their negative interactions with this colleague evoked emotions of hurt and anger, which lead them to consider having the clinician removed from the team:

I put a solution out on the table and their response was ‘What are you talking about?’ And I’m thinking ok, I must be talking [another language] here and later in the conversation somebody said the exact same thing I had proposed and they were like ‘Yeah, we could do it that way’. And I thought ‘Oh, you know what? That’s ugly’ It’s very hurtful. Yeah it’s very hurtful, yeah. It’s hurtful, it puts a block, it um, you know there have been days where I have actually said, ‘We do not need a [specific medical professional] on our service anymore (P4).

When medical professionals had poor experiences interacting with the treatment team or they experienced conflict between team members, they seemed to experience some reluctance in looking to the team for support. It was perceived that this might have resulted in an increase in negative emotions that were often directed toward other team members and that had a direct negative influence on client care.

Theme 3: Parental Factors that Interfere with Treatment (5/5)

All medical professionals indicated that certain behaviours displayed by the family evoked emotion in the clinicians, which subsequently influenced treatment decisions. Two subthemes emerged. First, some medical professionals seemed to feel anger in response to

resistant parents. Second, parents who were not able to offer support to their child evoked emotion of sadness and hurt for the child. For example, parents who did not ensure that their child was present at appointments or parents who also experienced mental health problems brought up anxiety and frustration in the medical professionals.

Subtheme: Parental Resistance in Therapy (5/5)

All medical professionals reported that when parents expressed anger or other strong emotions in direct opposition to treatment, it evoked fear and frustration that lead them to align with the parents regardless of the best interest of the child. For instance, a medical professional described a situation in which the parents' anger regarding the child's progress in treatment combined with threats of litigation resulted in the medical professional allowing the parents to participate in some components of treatment, but not others. By appeasing the parents and reducing their anger, medical professionals reduced their own fears around the parents taking legal action:

Their child wasn't getting better so, you know, it wasn't achieving the desired outcome for either the parent or the treatment committee and resulting in the family [...] basically trying to negotiate I guess with the program about who or what services, or part of the multidisciplinary would be involved in their child's care which again was negotiated with the family but was it was out of keeping with what would routinely be done with other families. Normally it's accepted that if you're going to be part of the program then [you would see] all members of the multidisciplinary team, (P3).

Parental denial was also reported to evoke frustration in medical professionals, which could then influence the treatment recommendations put forward. "Families often deny the seriousness of the condition and are often non-compliant with treatment recommendations. I

think it gets the better of us sometimes [...] and I see it change treatment recommendations” (P5). Another medical professional discussed frustration in the clinician that lead to a more specific influence on treatment decisions, including spending excessive time explaining and reassuring the parents of the medical professional’s competence:

I think sometimes what brings an emotional response from me to the parents is when the parents are very resistant to having their adolescents meet with the [specific medical professional] on their own and not respectful of their adolescents right to have confidential[ity]. [...], and I don’t think it’s the parents, well maybe the parents are feeling, anxious about what that is or why the [specific medical professional] would want to talk to their adolescent on their own [...] I think it brings up feelings of frustration, feelings the parents sort of distrust you as a medical provider, that you’re going to act ethically and in their child and their family’s best interest” (P3).

When asked to specify the ways in which emotional experiences may influence the medical professional’s decision-making in clinical practice, she responded saying:

Um, I probably respond by spending more time sort of explaining the reasons, you know, sort of behind doing some education around that. I probably respond by sometimes not being able to set appropriate like time limits around sort of clinical encounters because if that’s the way it presents itself. I feel it’s very important that the adolescents have that, right? And so, uh spending more time with that patient’s family to try to explain through the rationale behind that to lower the family’s, you know, anxiety or anger around that so the adolescent can have that as part of their experience when they’re coming to see me (P3).

When the medical professionals felt frustration toward noncompliant parents, they were sometimes unable to set appropriate limits around time spent trying to educate the parents to see things from their point of view. Additionally, the medical professionals felt frustration because it seemed as though they were being judged by the parents to be incompetent and untrustworthy.

Interactions with resistant parents may have resulted in increased anxiety and frustration in the medical professionals and participants provided examples of the ways in which these emotional states influenced clinical decision-making practices. However, the reactions varied depending on the emotions that were evoked. When the medical professionals felt anxiety in response to parental anger, they were more likely to align with the requests of the parents as a means of reducing their own discomfort as well as the likelihood of ongoing conflict. When the medical professionals felt frustrated, they reported set appropriate time limits around trying to educate the parents and get the parents on board with treatment, which again could have been a means of reducing their own discomfort as well as the possibility of escalating conflict.

Subtheme: Lack of Parental Support

Medical professionals reported being evoked by parents who were judged as unable to provide support to their child during the recovery process; however, the clinicians were not clear about the ways in which their emotions influenced clinical decision-making specifically. For instance, medical professionals' emotions, such as sadness and frustration were evoked when parents struggled to support their child through recovery: "We had um one little girl in particular where the mom has not been available to her and that's been very hard to watch. It's heart wrenching. Um, for me as the clinician it's very difficult" (P4). Seeing a child struggling without the support of a parent seemed to have a strong effect on medical professionals in that it aroused a great deal of sadness for the child.

Medical professionals also reported feeling sadness and frustration in response to dysfunction in family dynamics that interfered with the parents' ability to support their child:

I think it has more to do with maybe the level of dysfunction that might be present that might influence clinical decision making [...] maybe frustration, if there were circumstances that were happening that was making it difficult to care for the adolescent that would probably bring up feelings of wanting to like either frustration that treatment's not happening because of other factors that are happening within the family . Um or, feelings of um, wanting to help is not really a feeling, so I'm trying to just um...I guess, yeah, compassion for the patient that you're taking care of to want to sort of intervene and help. Maybe more maternalistic wanting to sort of intervene, um take charge of the situation (P3).

This frustration and sadness in the medical professionals seemed to be brought on by compassion for the child and a strong desire to see the child recover. It was difficult for medical professionals to see a child struggling and not have a support system in place. These feelings of sadness seemed to activate a caregiving instinct in the affected clinicians. Finally, some participants reported that parents who were not able to support their child due to their own issues could evoke emotionally charged decisions in themselves or others:

What is really tough is when parents become focused on themselves. [...] the clinician is getting a little frustrated with dealing with them with the other stuff [...] the child may be ill, but there are things that parent is doing that maybe is influencing their illness (P4).

This medical professional also described a specific case:

In one particular instance we have one of the clinicians working with a mom who is not a single mom and mom keeps being quite involved in her own life, brings her daughter to

the sessions when she's not supposed to and when she doesn't bring her daughter, she is blaming her daughter for bad behaviours. Um so there seems to be sabotage going on and the clinicians are like, 'What the heck? Like what is going on?' [...] This child ended up in inpatient treatment and there has been a case conference where the decision was that she be treated by another agency (P4).

The parent's inability to offer their child emotional support evoked frustration and confusion in the clinicians. The frustration and confusion on the part of the medical professional may have been due to the parents' inability to support their child as unwillingness to support their child.

Theme 4: Strong Negative Emotion/ Resistance in the Child (4/5)

Participants reported experiencing or observing others to experience strong negative emotion when faced with resistance from the child. In these instances, medical professionals often felt frustration or hopelessness that influenced decisions regarding caseload and discharge:

Different team members are having difficulty with how that adolescent may be engaging with them or if they're facing a lot of resistance, I've seen that often the response is to just want to sort of close the file and discharge them from the program as opposed to working with the resistance and working with what is workable. It's not appropriate to consider closing the file. They probably [feel] a sense of frustration, maybe a sense of personal ineffectiveness that they can't change this adolescent's mind about doing anything differently (P3).

Medical professionals sometimes made the decision to discharge the child when they felt that working with the client was "too difficult". Medical professionals' frustration may have come from the fact that treating resistant child-clients made them feel unable to proceed with

treatment or even incompetent in their work. By discharging the child and choosing to work with less resistant clients, the medical professionals may have been able maintain their personal sense of competence. That being said, alternative possibilities are equally likely. For instance, long wait-lists may have influenced the decision to discharge a child that they felt that they could not progress with to make room to admit a client that they could work with more easily. In addition, the fact that there is a physical component to treatment may lead the medical professionals to be more likely to discharge a “difficult” child-client if they are medically stable and perhaps they would not discharge if medical instability was a concern.

Another medical professional spoke of a case in which their emotions regarding a “difficult” patient with borderline personality disorder lead to changes in their standard practice:

I had a patient with borderline personality disorder who is very sick and we kept her out of hospital when I would have admitted other patients and the reason behind that is that she came into the hospital and it was so difficult to deal with her that I think that my feelings and my desire to avoid that level of conflict (laughs) sometimes led me to not admit her, when I would have very easily would have admitted someone else. [...I am] trying to avoid conflict. If I am honest with myself and these things are hard to be honest with yourself about because you hope that you make the same decision, but you don't (P5).

The data suggests that cases with resistance in the child-client made medical professionals feel frustrated and hopeless. In particular, because of medical professionals' desire to avoid conflict, they sometimes refused to work with individuals who were known to be argumentative or explosive.

Table 2

Theme	Emotional Processes	Clinical Decisions Influenced
1. Fear of Harm to the Child		
<i>A. Medical Instability</i>	Fear	Urgency of care
<i>B. Self-harm/ Suicidal Ideation</i>	Fear	Allocation of more time/ resources
2. Team Dynamic		
<i>A. Positive Dynamics</i>	Comfort with discussing emotions with team	Lesser influence of emotion on treatment decisions
<i>B. Inhibiting Dynamics</i>	Discomfort/Shame/Fear with discussing emotions with team	Refusing to treat clients who are close to other team member; Avoiding the inclusion of team members (i.e. medical professional) in treatment discussions
3. Family Factors that Interfere with Therapy		
<i>A. Parental Resistance</i>	Fear	Selective in treatment components that child has to engage in
	Frustration	Inability to set appropriate time restraints regarding discussing their point of view with parents.
<i>B. Lack of Parental Support</i>	Sadness; Hurt; Frustration	Not specified
4. Negative Emotion/Resistance in Child	Frustration; Shame	Discharge; Refer

Discussion Study 2

The results of Study 2 suggest that medical professionals are aware of being evoked in the context of health care delivery and the associated emotions were sometimes observed to have influenced treatment decisions. It was also evident that medical professionals felt that certain situations were more likely to lead to this phenomenon. Harm to the child through medical instability, self-harm behaviors, or suicidal ideation seemed much more likely to induce fear among medical professionals. This fear was believed to result in a motivation and sense of urgency to provide the child with necessary treatment. In addition, the dynamic of the treatment team was reported to influence the degree to which emotions seemed to influence medical professionals. Positive experiences were believed to lessen the impact of emotion on decision-making, while negative interactions with the treatment team were reported to increase the vulnerability of the influence on emotion on clinical care. Parental factors, such as parental resistance and lack of parental support also evoked emotions that were believed to influence treatment decisions. Finally, child-client characteristics, such as the display of strong negative emotions or resistance to treatment were reported to lead to anger or hopelessness; however, the ways in which hopelessness influenced clinical practice was unknown.

Study two examined the perception of the influence of emotions on clinical decision-making in child and adolescent ED in a sample of medical professionals. The results of the current study are of particular relevance as they play an important role in the treatment of children and adolescents with ED. To our knowledge, this is the first study that examines the role that emotions play in the context of medical care of child and adolescent ED.

Overall, the results of the study suggested that medical professionals do experience emotional reactions in response to this work, and in particular fear, frustration, anger, shame, and

sadness. These emotions were sometimes perceived to influence practice in a way that was helpful in the case of feeling fear and acting with urgency in the case of at-risk patients. In other instances, medical professionals' emotions were perceived to have a negative impact on client care.

Negative emotions, such as frustration and hopelessness were evoked in medical professionals when faced with an emotionally charged or resistant child and these experiences were thought to contribute to referral or early discharge. When it comes to medical professionals, Shapiro (2011) suggested that alexithymia (an inability to identify and describe their own emotions) and avoidance could actually be learned during medical professionals' education. Although medical education does not specifically promote professional alexithymia, curriculum may encourage students to separate or distance themselves from their own emotions and the emotions of their clients (Shapiro, 2011). If medical professionals are educated in a way that causes them to perceive emotions to be taboo in their practice, they may be less likely to be aware of their own emotions and the ways in which their emotional experiences can influence their practice. Alternatively, medical professionals' emotions may not be in their direct awareness.

In situations in which the medical professionals were faced with parental resistance, they felt fear and frustration that influenced treatment decisions. Similarly to study one in the case of therapists, these findings expand on the results of the study by Lafrance Robinson and Kosmerly (2015), which suggested that parental resistance is the most common decision perceived to influence clinician emotion. Again, although the present study did not directly measure the most emotionally charged decision, all five medical professionals perceived that parental resistance impacted their ability to make sound treatment decisions.

Interestingly, the dynamic of the treatment team seemed to influence the degree to which emotions were perceived to affect clinical practice. Medical professionals believed that negative experiences with the treatment team might have influenced their decisions to include certain team members on their service. They also perceived that when colleagues experienced dislike for a member of the team, they were less likely to agree to provide service to a child who had a strong relationship with that team member. Given the extent to which negative treatment team was perceived to impact client care, actions should be taken to ensure that treatment teams provide a healthy environment for consultation and that all members are acting toward a common goal: to increase the effectiveness of client care. In order to accomplish this goal, the treatment team must develop a balance of strong working relationships. A study by Dieleman et al. (2004) found that working in a team environment was perceived to be very beneficial when working with complex primary care patients. Results suggested that open communication, respect for other team members, understanding of their roles and expertise, and being open to learning was important for collaboration. However, in order for team members to trust each other, they had to learn about the professions of the other providers and determine what knowledge, skills and abilities they could offer the team.

Most importantly, providers felt that effective communication was important to information that they needed and consequently improve patient care. Teams found that taking the time to become comfortable with each other enhanced their communication, which translated into improved care and higher rates of job satisfaction. In Study 1, it was discussed that although positive relationships amongst treatment team members were perceived to reduce the impact of emotions on treatment decisions, it did not completely prevent emotional influences on clinical practice. One explanation was that groupthink (Janis, 1972) could be occurring amongst the

treatment team. As such, while increasing the cohesiveness of treatment teams may be necessary to improve client care, it is also important to ensure that groupthink does not occur.

Given that Dieleman et al, (2004) found that collaborative teams improved job satisfaction and patient care, it is important that ruptures in the treatment team be addressed. It may be beneficial for programs to implement team-bonding opportunities and team skill building activities. For example, perhaps teams that are experiencing disconnection could be provided with a professional training program designed to improve the dynamic of the treatment team. In this regard, it may be helpful for research to address the effectiveness of bonding experiences, through group activities, such as yoga or team lunches as they may increase the comfort level amongst team members. Additionally, it may be helpful to provide education for team members to learn about all disciplines included in the team to ensure that they are aware of the various perspectives and knowledge that each member can offer the team. To prevent groupthink from occurring, it may be helpful to implement of system that allows members of treatment teams to anonymously present their opinion regarding the evaluation of treatment decisions. For instance, perhaps team members could be presented with the case and then be asked to anonymously write their opinions and place them in a box prior to any team discussion.

Not all emotions evoked in medical professionals were reported to have a negative influence on decision-making. In certain situations, emotions were regarded as helpful in clinical practice. Fear of harm to the child provoked fear in the medical professionals and caused the medical professionals to respond with seemingly appropriate urgency. The medical professionals' responsibility in the treatment of child and adolescent ED is ongoing medical monitoring (Katzman et al., 2013). It is fitting that a threat to the child's medical stability would evoke fear, as the medical professionals may feel a sense of liability with regard to ensure the

child's health is improving. Interestingly, medical professionals seemed to react with urgency in cases involving individuals with anorexia nervosa. Such urgency may be because individuals with anorexia nervosa often appear emaciated, where as individuals with bulimia nervosa often appear average in size. Individuals with anorexia nervosa may receive more urgent care due to the fear induced in medical professionals by their physical appearance. Differences in care is problematic because although individuals with bulimia nervosa often appear average weight, they should bring about fear in medical professionals because these individuals can often be quite medically unstable.

While the medical professionals' reactions of fear for the child's safety may have been appropriate in motivating delivery of care, it may have negatively affected the clinician's well-being. For instance, some medical professionals discussed that they experienced worry regarding the health of the child on a constant basis, even seeing their clients in their dreams. Experiencing constant thoughts and fear regarding their clients' well-being may increase the likelihood of burnout amongst medical professionals. Past research has suggested that health professionals working in the field of ED may be at risk for experiencing job burnout and emotional exhaustion (Warren et al., 2013). It is important that burnout prevention and intervention is available for medical professionals. For instance, hospital programs could ensure that medical professionals are working in a positive team environment and have access to peer support and counseling services. For instance, it may be beneficial to implement programs that help medical professionals to cope with fear, anxiety, and other feelings brought up when working with life threatening illness, such as ED. ED programs may implement mandatory personal therapy to ensure that health professionals working with life threatening illnesses receive the psychological support that they need. Alternatively, programs could provide anonymous support to health

professionals by establishing hotlines or Internet support groups specifically designed to meet the needs of health professionals working with ED.

Lafrance Robinson and Kosmerly (2015) conducted a survey of ED clinicians practicing in Canada and results indicated that therapists were likely to underreport the degree to which emotions influence their clinical practice. Lafrance Robinson and Kosmerly (2015) results also seemed true in the present study as data suggested that medical professionals were often reluctant when discussing the role of their emotions in decision-making practices. This reluctance may have been due to the fact that medical professionals may not be accustomed to thinking about emotions regularly in clinical practice, which may be because of their workload, the pressure they have to treat multiple patients in a relatively short period of time, and perhaps the training they received. For instance, in medical school, medical professionals may have learned to make their decisions in black or white fashion, such that there is a right and wrong decision, which should not be influenced by personal factors, such as emotions. The reluctance to discuss emotions initially might also be due to the fact that medical professionals have learned to distance themselves from emotions in practice (Shapiro, 2011). Alternatively, it could be that the impact of their own emotions in clinical practice is not in their direct awareness. It could be beneficial to incorporate emotion recognition training into medical programs. Incorporating emotion recognition training into medical professionals education may allow medical professionals to develop a level of comfort in allowing themselves to recognize and experience emotions, use their emotions in an adaptive way, and achieve a balance with regard to acknowledging emotion rather than avoiding emotions altogether.

It is important that the topic of emotion be brought to light in medical practice and that the field begins to discuss the issue. Medical professionals are human and are likely experiencing emotions in practice; however, they may be experiencing a great deal of discomfort when it comes to emotions affecting their practice, as evidenced the tendency to underreport emotions as present in clinical practice (Lafrance Robinson and Kosmerly, 2015). Alternatively, emotions experienced in clinical practice may not even be in the medical professionals awareness. If this is the case, it may be beneficial to encourage self-reflective practices in medical professionals. An open discussion around the influence of emotion on clinical practice may reduce the negative impact of emotions on decisions, which may in turn increase quality of care for children and families in ED treatment.

CHAPTER FIVE: GENERAL DISCUSSION

Both medical professionals and therapists reported that emotions were present in clinical practice and it was perceived that emotions influenced decision-making. Similarities were noted, as were discipline-specific differences. With regard to similarities, both medical professionals and therapists experienced fear and frustration related to family resistance, and reported that positive experiences with the treatment team resulted in a decrease in emotional influences on decisions.

Medical professionals and therapists both attended team meetings and agreed that positive experiences with the team were helpful to reduce the impact of emotions on decision-making in clinical practice. It is possible that the positive experiences with the team indirectly reduced the negative impact of emotions on decision-making. For instance, positive experiences with the team may have lead to a more pleasant work environment and increased overall job satisfaction. When clinicians were happy and satisfied with their job, they may have been less likely to experience strong negative emotions and when they did experience unpleasant feelings, the positive environment may have inadvertently lessened the intensity or duration of these emotions and as such, they were less likely to negatively affect client care.

Both therapists and medical professionals also perceived that when experiencing frustration, both themselves and their colleagues had a tendency to resort to early discharge. When children or families appeared angry or resistant, therapists may have felt frustration because they felt that their time could be spent providing treatment to a child or family that appeared to be more compliant with treatment. They may have felt frustrated because the extra time and resources they had to expand on resistant clients could have been used to offer support to others who also needed their attention.

Therapists and medical professionals were able to identify emotions that they perceived to influence decision-making practices; however, it seemed as though there were many instances in which both therapists and medical professionals experienced underlying feelings of incompetence. For instance, in terms of discharge, when therapists felt fear for the client's well-being, they perceived that they were more likely to prolong discharge. While therapists may have felt fear for their clients, therapists also indicated that they felt as though they did not do enough to ensure that the client was able to manage recovery outside of treatment. In the case of frustration, therapists perceived that frustration lead them to discharge early due to reasons such as an inability to develop a therapeutic bond; however, therapists may have felt a lack of self-efficacy in their ability to provide treatment to individuals that were resistant. Rather than risk failing and being judged by colleagues or parents, discharging the client may have been a way to protect the therapists from their own negative feelings of incompetence. Medical professionals experienced similar feelings. For example, when medical professionals were faced with angry parents, they were likely to experience frustration and as such, felt that they had to spend excess time explaining their treatment approach to convince parents that it was valid. In such instances, medical professionals seemed to be experiencing underlying feelings of incompetence in their ability to successfully treat the family. They may have overcompensated and spent excess time explaining their approach to parents as a means of validating their competence.

Differences that emerged between therapists and medical professionals could likely be attributed to diversity in the nature of training programs and professional philosophy as well as differences in areas of competency and responsibility between the two professions. With regard to differences between therapists and medical professionals, therapists perceived that their relationship or interactions with the child/family and self-reflective practices had a profound

influence on treatment decisions. Conversely, medical professionals reported feeling fear in response to harm to the clients and emotion evoked through negative experiences with the treatment team influenced their ability to make sound treatment decisions.

Therapists discussed that emotions of frustration were often evoked, particularly when the therapeutic relationship was strained, whereas medical professionals did not. Therapists certainly learn about the importance of the therapeutic relationship early on in their training and it is typically a primary objective given the research that the therapeutic alliance is one of the more robust predictors of treatment outcomes in ED (Zaitsoff, Pullmer, Cyr, & Aime, 2015). It is also common practice for therapists to meet with clients on a regular basis and in a more intensive way relationally. During meetings between therapists and clients, clients may disclose personal information regarding thoughts, feelings, and past experiences and a strong bond may form, which may be an indicator of therapeutic success. In comparison to therapists, medical professionals may not see clients as regularly and appointments may be shorter in length and more focused on physical symptomology. Given the role of the physician when working with child and adolescent ED, they also may not have the opportunity to discuss personal information, such as feelings and past experiences and so deep therapeutic bonds may not develop as readily as they do with therapists. As such, it makes sense that therapists perceived the therapeutic alliance had a profound impact on the ways in which emotions influence treatment decisions.

Interestingly, therapists discussed that self-reflective practices were important because such practices enabled the clinicians to be more aware of their own emotions in therapy. Medical professionals did not discuss self-reflective practices as a means of reducing the influence of emotions on decision-making practices. Again, this may be due to the nature of their training, as medical professionals are often taught that to be successful, they should distance themselves

from their emotions and the emotions of their colleagues (Shapiro, 2011). Conversely, therapist training involves learning about emotions, transference/countertransference and sometimes even involves a personal therapy component. As such therapists may be more aware of their own emotions and the way that their emotions can affect clinical practice.

With regard to medical professionals, it made sense that medical professionals felt fear when it came to the health and safety of the client. In terms of medical instability, medical professionals are trained to treat physical illness and physical complications, where as it is not part of therapists' duties. Because medical professionals work with physical health on a daily basis and have more experience in the area than therapists, they may be hyperaware of the severity of the illness and possible outcomes if not treated in a timely manner. In addition, the role of the medical professional is medical monitoring of the client. As such, it is possible that medical professionals felt a sense of responsibility to ensure the medical stability of the client. Additionally, medical professionals discussed that self-harm and suicidal ideation in client evoked fear and anxiety in the medical professional while therapists did not. It is possible that therapists are more comfortable with dealing with suicidal thoughts and working through self-harm with clients as a result of training and repeated exposure in clinical practice.

Differences between training in therapists and medical professionals and comfort level with experiencing emotions in practice may have contributed to the fact that therapists seemed more likely to openly discuss the fact that emotions were present in clinical practice and that they had the potential to influence decision-making. Although some medical professionals reported that emotions were present in clinical practice and influenced decision-making, one medical professional did not believe that emotions impacted clinical practice at all. As the interview proceeded, this medical professional concluded that emotions were present, especially in her

colleagues. Others suggested that although emotions were present, they did not influence their decision-making. The fact that medical professionals were more reluctant to discuss the influence of their own emotions on their clinical practice is likely because their training programs focus on a medical model and emphasize objectivity in treatment. On the other hand, training programs for therapists often include an examination of their emotions or in some cases require mandatory personal therapy.

In combination, the results of Study 1 and Study 2 provide evidence that therapists and medical professionals perceive their emotions and those of their colleagues to influence their abilities to make sound clinical judgments. Although therapists' and medical professionals' emotions were perceived to influence decisions and there were similarities with respect to positive experiences with treatment team and decisions around discharge and child-client resistance, differences also emerged. These differences were likely due to differences in training and practice, which also may correspond to comfort levels in recognizing and discussing emotions as present in practice. Regardless of therapists and medical professionals level of professional expertise in their respective disciplines and their good intentions when delivering treatment, their own affective experiences may be inadvertently compromising the quality of care that they are able to provide to clients and families experiencing ED. By allowing their own emotions to dictate certain decisions, therapists may inadvertently decrease the effectiveness of therapeutic efforts; however, more research is needed to determine the relative impact of this phenomenon, as we do not yet know the definite impact of emotions on clinical decision-making. The following sections will discuss the strengths and limitations of the current study and provide important directions for future research. Finally and most significantly, the implications of the present study on clinical practice will be discussed.

5.1 Limitations and Trustworthiness

This study is not without limitations. A selection bias may also be present, given that the sample was recruited on a volunteer basis from Lafrance Robinson and Kosmerly's (2015) original sample. As such, these clinicians may have been particularly interested in the influence of emotion on clinical practice. In addition, therapists and medical professionals reported that FBT was a primary treatment modality; however, FBT was not the only treatment that was used, as therapists and medical professionals in the study reported practicing individual therapy as well. As such, therapists had experience working with children and families as opposed to only working with families. The results of the study then do not solely reflect the experiences of clinicians working with families using FBT. Furthermore, it is noteworthy that the present thesis is based on therapist and medical professionals' perceptions and that definitive conclusions regarding the actual impact of emotions on clinical decision-making cannot be drawn. Finally, it is important to consider that two different researchers carried out participant interviews and data analysis. As such, the audit trail is only present for the data analysis phase of the study and not for the interview process. However, prior to data analysis, I listened to audio-recorded versions of the interviews and noted observations regarding rapport, communication style, and tone of voice.

Despite these limitations, trustworthiness of the data was maintained. Prior to data collection, the interview schedule was pilot tested with child and adolescent ED clinicians and feedback was sought and integrated. Interviews were audio recorded to ensure the accuracy of participants' thoughts and feelings. During the interview process, the interviewer engaged in reflective listening and interpretation, which means that the participants were asked to clarify wording or information if any further clarification was required. In order to ensure the

trustworthiness of qualitative analysis, the researcher must be as transparent as possible (Guest, MacQueen, & Namey, 2012). Transparency in qualitative research refers to making the research process as visible as possible to readers (Guest et al., 2012).

Progressive subjectivity has been identified as a means of increasing credibility in research (Mertens & McLaughlin, 2004). Progressive subjectivity involves the credibility of the researcher and monitoring their developing constructions and documenting the changes throughout the process of the study from beginning to end (Guba & Lincoln, 1989). During the data analysis phase, the researcher kept a reflexive journal to ensure that an audit trail was present. An audit trail helps to increase the transparency of the analyses as the researcher keeps a detailed account of the methods and procedures used and the decision-making process (Merriam, 2002). Audit trails involve the documentation of the entire data analysis process. In a notebook, I documented the details of the data analysis process, including the ways in which themes were derived and any overlap that was discovered between themes. Although documentation and description of procedures taken during the analysis does not guarantee trustworthiness, it does provide information for others to review and draw their own conclusions regarding the credibility of the research (Guest et al., 2012).

In qualitative research using basic interpretive approach, the researcher is the research instrument (Merriam, 2002) and as such, the researchers own biases and changes in perspective can influence the results derived from the data, which can decrease the trustworthiness of the research. To increase the credibility of the present thesis, I presented my own experiences, training, and perspectives in a reflexivity section.

Finally, member checks were also reported as a way to increase credibility in qualitative research (Merriam, 2002). Member checking was completed to ensure that the themes that

emerged accurately represented the participants' experiences. Member checking involved sending participants a summary of the themes and allowing them the opportunity to provide feedback regarding whether or not they believed the themes accurately reflected their experiences.

5.2 Future Directions

More research is needed to determine the degree to which emotion in clinical practice is underreported. Because therapists were asked about their perceptions of the ways in which emotions influence decision-making practice, definite conclusions cannot be drawn. Future research may aim to explore this phenomenon using an experimental paradigm to draw more definitive conclusions regarding the impact of emotions on decision-making in both therapists and medical professionals.

Research should also continue to examine the perceived stigma associated with therapists and medical professionals openly discussing emotions in clinical practice as well as evaluate strategies to reduce stigma in health care settings. It is particularly important to examine medical curriculum to further determine the ways in which medical professionals may be inadvertently encouraged to avoid emotion in clinical practice (Shapiro, 2011). It would also be beneficial to continue to examine ways to promote an open dialogue regarding emotional experiences and the ways affect client outcomes. It is important to explore this phenomenon because in order to ensure that emotions do not negatively influence clinical decisions, clinicians first have to develop a higher degree of comfort with open discussion regarding the ways in which emotions are influencing their decisions in practice.

Both therapists and medical professionals perceived that the treatment team was important when it came to emotional influences on decisions. As such, research should turn to

examining factors that encourage collaborative treatment teams as well as factors that improve ruptures in team cohesiveness. It may be of particular relevance to examine the effectiveness of team skill building experiences and team bonding opportunities as a way to promote connectedness and comfort amongst team members.

While the current thesis provides partial support for Waller's (2009) Therapist Drift Model in that negative emotions were perceived by therapists and medical professionals to impact client care, neither therapists or medical professionals discussed the influence that positive emotions, such as excitement, joy, gratitude and interest had on their treatment decisions. As such, we are unable to determine if positive affect was perceived to have a negative impact on decision-making practice, as theorized by Waller (2009) or if positive emotions were perceived to be helpful in decision-making practice. Future research should turn its attention to examining the ways in which positive emotions influence therapists and medical professionals' ability to make decisions. Research could investigate this phenomenon qualitatively through interviews or experimentally. For instance, interview questions could include: "Are there times when you feel positive emotions when working with child and adolescent eating disorders? What types of positive emotions do you feel in practice? How do you think you think these positive emotions influence your treatment decisions?"

Finally, it may be beneficial to examine the degree to which emotional processed influence burnout, as high levels of burnout are reported in clinicians working with ED (Warren et al., 2013). It would be of particular interest to determine whether burnout mediates the relationship between emotions and their effect on clinical decisions.

5.3 Implications for Clinical Practice

The results of the current thesis have implications for clinical practice. In particular, therapists and medical professionals both perceived that frustration influenced their decisions regarding discharge. Due to the nature of the therapist and medical professionals working in child and adolescent ED, emotions will always be present in practice. It is important that the field establish safe guards to prevent against premature discharge of child-clients. Such safeguards may include an evaluation of the clinician's emotions and reasoning behind discharge. In cases in which multiple team members are experiencing strong emotion, perhaps a secondary treatment team can be brought in to consult on cases. This would enable clinicians to have contact with impartial professionals with whom to consult when they feel that their emotions may be negatively affecting their decision-making process.

It may also be beneficial to work with clinicians to emphasize the importance of developing strong therapeutic alliances with clients, as it is shown to benefit the client receiving treatment. Specifically, it is important that clinicians are aware of actions that they can take when they experience difficulty developing or maintaining a therapeutic alliance. It is necessary that therapists be educated on the process of the development of the therapeutic relationship, including an awareness that alliances will develop more slowly with some clients perhaps due to client histories or the nature of ED. Ensuring that therapists allow ample time for the therapeutic alliance to develop could help to reduce the number of clients who are discharged due to frustration brought on by weak therapeutic alliances. In particular, clinicians working with child and adolescent ED are confronted with unique challenges in building strong therapeutic alliances. For instance treatment resistance is a common feature of ED (Halmi, 2013), which may cause frustration in therapists, as it may seem difficult for therapists to develop an alliance with a client who appears to be resistant to their efforts. In addition, individuals with ED have

been found to have difficulty building and maintaining interpersonal relationships (Broberg, Hkalmers, & Nevonen, 2011) and it has been suggested that insecure attachment has been related to several characteristics of ED behavior (e.g. Chassler, 1997; Troisi et al., 2005; Candelori and Ciocca, 1998). Tasca and Balfour (2014a) reported that ED psychopathology is viewed by some as being caused by abuse, neglect, bullying, partner violence, or mismatch between caregiver's abilities and a child's needs. Research by Tasca (2016) indicated that interpersonal problems and sensitivities, lack of social skills, low social support, and problems with romantic intimacy can be contributing factors for the development of ED psychopathology. Given the research on difficulties in attachment and relationships in individuals with ED, it is especially important that therapists be aware of the possibility of attachment difficulties in their clients as a possibility for difficulties in establishing a therapeutic alliance. It is also important that therapists are sensitive to these unique struggles experienced by individuals with ED and provide an environment that fosters the development of a positive therapeutic alliance.

The present thesis also sheds light on the importance of the treatment team in clinical practice. Clinicians reported that being a part of a healthy treatment team served as a protective factor against emotionally charged decisions in clinical practice. Clinicians suggested that when the treatment team fostered an accepting and open environment, therapists felt more comfortable bringing troublesome emotional experiences to the team for support. As such, actions should be taken to ensure that treatment teams foster an environment in which discussion around emotions and their impact are accepted and encouraged. More importantly, given the negative impact that treatment team ruptures were perceived to have on client care, it is necessary that measures be put in place to improve the team dynamic in disconnected treatment teams. Such strategies could involve skill-building activities, educational sessions in which team members learn about other

disciplines within their teams and the expertise that each has to offer. Moreover, events could be encouraged to promote team members to get to know each other outside of the work setting and to develop a level of comfort with the team.

Given the fact that resistant families were perceived to evoke emotion that influenced decision-making in all clinicians interviewed in the current study, it is necessary to address this issue. Often families who appear resistant are experiencing their own strong emotions, such as fear, hopelessness, helplessness, self-blame, etc. that may cause them to act in ways that frustrate or anger clinicians. It is necessary that clinicians receive training regarding the ways in which they can effectively work with and understand the challenges of resistant parents. Such interventions may involve working with parents to process their own emotions surround their child's ED as well as working through their own emotions regarding the parents in treatment.

It is also important that medical professionals and therapists be aware of their own emotions in clinical practice as well as the effects that their emotional experiences can have on treatment decisions. Shapiro (2011) suggested that medical professionals may be particularly ashamed of experiencing emotions in practice, as such, a first step could be promoting self-reflective practices amongst medical professionals. This first step may enable medical professionals to become more aware of their own emotions and better able to process their emotional experiences. A next step could involve training in emotion regulation skills to ensure that medical professionals are aware of their emotions and experiencing their emotions, but are also able to appropriately regulate their affective experiences in practice. Additionally, it may be necessary to change the medical curriculum to ensure the medical professionals receive more training in the treatment of ED, especially since medical professionals play a vital role in the treatment of child and adolescent ED. More specifically, the results of the current thesis suggest

it may be necessary to train medical professionals in the importance of involving the family in therapy. It is also necessary that therapists and medical professionals understand the importance of developing a strong and secure relationship with families in order to ensure a safe environment in which the family to trust in the medical professional/therapist and for the medical professional/therapist to be feel competent in their ability to deepen in therapy without fear of rupturing their relationships with families or pushing the family too far in the sense that they withdraw from treatment. Furthermore it is important that both medical professionals and therapists recognize the ways in which their own emotions could influence their ability to deliver client care.

It is also important that therapists and medical professionals address underlying feelings of incompetence that may be driving their emotions that were perceived to impact treatment decisions. While fear or frustration may be the emotion that they perceive they are feeling, it is important that therapists and made aware of their primary emotions of incompetence in order to address the influence that feelings of incompetence has on their practice. This may be addressed through education in that therapists and medical should be made aware of the ways that feelings of incompetence can influence their practice. Supervision teams should also be in trained in how to bring up issues of incompetence in therapists and medical professionals as well as be educated in ways to work through these issues. Finally, in some cases it may be beneficial for therapists and medical professionals to seek out their own therapy. Due to the stigma and feelings of shame that may be associated with health professionals receiving their own therapy, it would be helpful for hospitals, independent practices, and regulatory bodies ensure that options to be made available in order to encourage health professionals to receive their own personal therapy.

Though self-reflective practices and supervision are suggested to reduce the impact of clinicians' emotions in clinical practice, therapists are presumed to be engaging in these practices. While therapists in the current study perceived that self-reflection seemed to reduce the degree to which emotions impacted decisions, therapists reported that despite these practices, emotions were still present in clinical practice and actively influencing decision-making practices and treatment outcomes. Other interventions, such as personal therapy (as suggested by some therapists) may be required to allow clinicians to work through personal issues to ensure that these do not interfere with therapy. Additionally, it may be beneficial to encourage or even require continuing education to allow therapists and medical professionals to become aware of the ways in which their emotions impact their practice in order to develop strategies to ensure that their emotions do not negatively influence client care. Finally, it may be important to incorporate the role of emotional influence on clinical decision-making in therapist curriculum.

Conclusion

The present thesis serves to raise awareness to and to continue an important conversation regarding the issue of emotional influences on clinical practice and the drastic, life-threatening effects that this phenomenon may have on child and adolescents with ED. The issue of clinicians' emotions influencing treatment outcomes must be acknowledged and openly discussed by clinicians in the field in order to bring about change and provide treatment that is in the best interest of the client. It is especially meaningful for medical professionals working with child and adolescent ED, as this topic has not yet been examined in the research.

CHAPTER SIX: REFERENCES

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APPENDICIES

Appendix 1 103

Appendix 2 105

APPENDIX 1

Ethics Approval

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS
Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New / Modifications to project X / Time extension	
Name of Principal Investigator and school/department	Sarah Penney Psychology MA, with Stacey Kosmerly and Adele LaFrance Robinson, Psychology
Title of Project	The perception of the influence of emotions in clinical decision-making in child and adolescent eating disorders: A Canadian Study
REB file number	2012-08-03
Date of original approval of project	August. 28, 2012
Date of approval of project modifications or extension (if applicable)	June 24, 2015
Final/Interim report due on: <i>(You may request an extension)</i>	June, 2016
Conditions placed on project	

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*

Interview Schedule

Before we begin the interview, did you have a chance to review the consent form I sent via email? Do you have any questions? Do you consent to participate in the interview? I will be documenting our conversation using an audio recorder in order to compare interview transcripts following the study to look for emerging themes. If you wish to stop the interview at any time, please let me know and I will stop the recorder.

Now, I'm going to ask you a bit about yourself to situate myself before we get into the interview questions.

1. What is your role in working with child and adolescent eating disorders?
2. How many years of experience do you have in this role?
3. Do you work in a rural or urban setting?
4. What type of program do you work in (i.e. hospital, mental health clinic, private practice)?
5. What proportion of clients do you see that are: restricting type, bulimic type or binge eating? Other?
6. What level of treatment do you provide (outpatient, partial hospitalization/day tx, inpatient)?
7. What is your primary orientation for pediatric ED treatment?
 - o If FBT – what type? Traditional or modified? Multi-Family Therapy version or a hybrid?
8. Do you work on your own or as part of a team?

Evidence suggests that it is not possible for clinical decisions to be made completely independent

of emotion. We want to get your thoughts regarding the influence of emotions on clinical decision-making in working specifically within the field of child and adolescent eating disorders - both in yourself and in others. All interviews are anonymous and confidential, I am the only one conducting interviews, and the research team will only have access to anonymous transcripts. We really value your feedback because the lived experience of this phenomenon may help to inform future practice. Please answer all questions as honestly as possible. If any of the questions make you feel uncomfortable please try and answer to the best of your ability and know that you have the option to pass if you feel unable to answer. Do you have any questions?

1. Thinking about your colleagues: When working with child and adolescent eating disorders, how do clinicians' emotions influence clinical decision-making?
 - a. Can you tell me more? Can you give me some examples?
 - b. What about for you? Can you tell me more? Can you give me some examples?

(ensure you are getting to how emotional reactions in the clinicians influence clinical decision-making)
2. Thinking about your colleagues: Which clinical decisions are the most influenced by a clinician's emotions? (i.e. setting goal weights, recommending tertiary care, etc.)
 - a. Can you tell me more? Can you give me some examples?
 - b. What about for you? Can you tell me more? Can you give me some examples?

(ensure you are getting to how emotional reactions in the clinicians influence clinical Decision-making)
3. Thinking about your colleagues: which populations or family structures are clinician's

emotions more likely to influence clinical decision-making? What about for you? Can you tell me more? Can you give me some examples?

- a. Working with older an adolescent vs. a younger child; Tell me more about how emotional reactions in the clinicians influence clinical decision-making in that context.
 - b. Working with parents vs. children/teens; Tell me more about how emotional reactions in the clinicians influence clinical decision-making in that context.
 - c. Working with an intact family vs. a separated, divorced or blended family; Tell me more about how that happens? Tell me more about how emotional reactions in the clinicians influence clinical decision-making in that context.
 - d. Anorexia-like presentations vs. bulimic-presentations; Tell me more about how that happens? Tell me more about how emotional reactions in the clinicians influence clinical decision-making in that context.
 - e. New diagnoses vs. chronic cases; Tell me more about how that happens? Tell me more about how emotional reactions in the clinicians influence clinical decision-making in that context.
4. In which settings are clinicians' emotions more likely to influence clinical decision-making?
- a. Residential vs. Inpatient vs. Outpatient vs. Day treatment program
 - b. When working as a part of a team?
 - c. Any particular discipline that you perceive as more vulnerable to this phenomenon?
5. Which emotions displayed by clients do you think lead to a reaction in the clinician, which in

turn influences clinical decision-making? (i.e. Reactions of sadness, anger, anxiety, disgust, fear, depression, hopelessness, helplessness, shame, guilt, flat affect/shut-down, excitement, happiness?) For example, if a teenager displays anger, it may lead to the clinician feeling angry and clinical decision-making may be affected. If a child displays hopelessness and sadness, a clinician may feel afraid they will push that child into a depression and perhaps make smaller adjustments to the meal plan.

- a. Can you tell me more?
- b. How is it different/same when this emotion is presented by the parent?
- c. How is it different when this emotion is presented by other clinical colleagues? (i.e. if the colleague is having an emotional reaction).

6. Is there anything to do with the delivery of family-based therapy specifically that increases the risk of emotions having an influence on clinical decision-making?

- a. Can you tell me more?

7. What are your thoughts regarding the role of clinician's emotion when considering an involuntary admission for children and adolescents?

- a. What about when it comes to adults?

8. To what degree, if any, do you see the role of emotion in clinical decision-making to be problematic/helpful?

- a. How easy or difficult is it to self-reflect on these issues, and/or talk about these issues with your colleagues?

- b. How do you and your colleagues typically deal with this phenomenon when observed?
 - c. What is currently being done to reduce the negative influence of emotional decision-making?
- 9. Some clinicians talk about fears, frustrations, or even shame influencing their clinical decision-making. Can you relate to this? Either having experienced it yourself or observing it in your colleagues?
- 10. Is there anything else you would like to add about the influence of emotions in clinical decision-making in working with child and adolescent eating disorders?

Thank you for participating in this research study. It was a pleasure talking to you and your input was incredibly valuable. I'll be in touch regarding the results in order to perform member checking, that is, in order to insure the themes we identify reflect your experience.

Thank you again for your time.